DROPPING OUT: FEMALE EX-ALCOHOLICS ANONYMOUS ATTENDEES AND THE PROCESS OF LABELING

By

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Bachelor of Science

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Platteville, Wisconsin

1981

Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
MASTER OF SCIENCE
December, 1989

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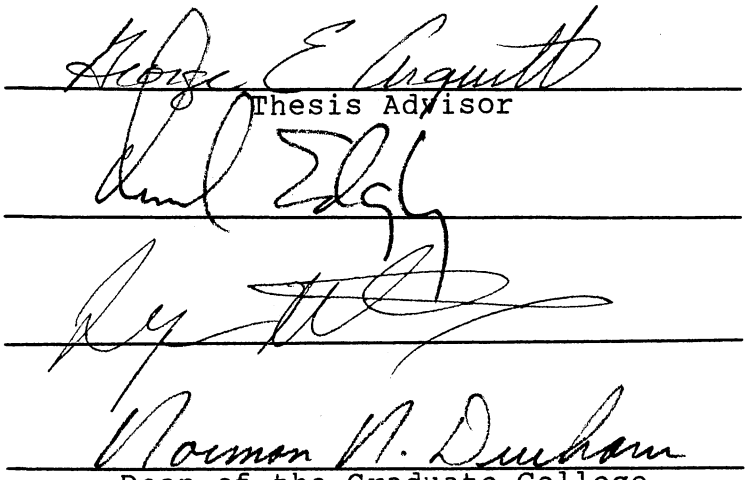

Thesis Advisor

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ACKNOWLEDGEMENTS

A number of people were instrumental in helping me to accomplish this research. First, my advisor, Dr. Ed Arquitt, played the major role in guiding my efforts. He offered an immeasurable amount of support and advice, as well as a comfortable yet challenging atmosphere in which to complete this study. I also wish to thank my other co-advisors on this project, Dr. Lynn Atkinson and Dr. Charles Edgley, for their suggestions, "prodding," and affirmations.

Second, some of my friends and fellow students deserve mention due to the large amount of friendly advice, commiseration, and stress relief that they offered. In particular, I wish to thank Dahlia Gonzalez, Stuart Cornell, Mary Provost, and Stephanie Hallisy for their efforts to keep me sane.

Finally, I wish to extend the most gratitude to the ten women who participated in this study. The information with which they provided me revolved around sensitive personal issues, yet they opened up their lives for examination out of a belief that others may gain insight from their vulnerability. I am deeply indebted to them, and hope that, in some way, they have benefitted (as I did) from examining the issues explored in this research.

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CHAPTER I

INTRODUCTION

Statement of the Problem

Alcoholism is a growing concern in the increasingly health-conscious United States. In a country where seven out of every ten people drink (Denzin 1987), alcoholism affects an estimated 10,000,000 people (Zastrow and Bowker 1984) and is considered to be the third-ranking health problem in the country (Denzin 1987).

Women comprise one-third of the alcoholic population (Sandmaier 1980), yet rehabilitation programs treat far fewer women in proportion to men (Beckman and Amaro 1984-85). Treatment prognoses for the women who do seek treatment are varied, and often depend upon which model of alcoholism the assessor uses. Macdonald (1987) and Haver (1986b) suggest that no one factor is influential in treatment outcome, including the treatment itself. Other researchers comparing women to men find that men have better prognoses (Denzin 1987; Schuckit and Morrissey 1976) or that women do as well (Fox 1979; Duckert 1987) or better under certain circumstances (Schuckit and Morrissey 1976). Haver (1986b), Pattison (1966), Rimmer, Pitts, Reich, and Winokur (1971), Shore and Kofoed (1984), and Kissin

("Theory," 1977) consider social factors to be related to prognosis; that is, alcoholism and its consequences and rehabilitation might depend less upon alcoholism as a disease or a psychopathology than on the stresses and pressures that affect everyone.

Alcoholics Anonymous is a program of alcohol rehabilitation that is popular among health care professionals and the general populace as well; it is the program overwhelmingly chosen by professionals for referral (Tournier 1979). Keller (1986) assumes that no one who is referred to AA is harmed by it, and Kissin ("Theory," 1977, p. 71) states:

> A.A. has been found almost universally to be an effective therapy or therapeutic adjunct in the treatment of alcoholism. Almost every patient should be referred to A.A. unless there are some specific contraindications.

Included in this list of "contraindications" are inappropriateness of the particular AA group for the client, strong disapproval from the AA group toward other therapeutic approaches, strong disapproval from the alcoholic's family against joining AA, and the patient's dislike of his or her experience in AA (Kissin "Theory," 1977). Factors such as these cause concern among researchers (Tournier 1979; Curlee-Salisbury 1982; Rudy 1986); Baekland (1977, p. 427) states that "the general applicability of A.A. as a treatment method is much more limited than has been supposed in the past."

Given the number of women in treatment programs, their uncertain prognosis for rehabilitation once in

treatment, and the questionable applicability of AA as the appropriate method of recovery, a bleak picture is painted for female alcoholics. Even bleaker is the knowledge that the drop-out rate in outpatient treatment is as high as 75% before the fourth session (Baekland and Lundwall 1977).

This study seeks to explore the experiences of women who have attempted recovery through AA. Since AA is purportedly the most successful treatment program available for people with drinking problems, a look at some of the people who no longer attend Alcoholics Anonymous meetings may shed light on why AA also has a large dropout rate. The focus is not on the AA program as such, however, but on the women who have gone through its doors and exited. Hopefully, this focus will generate a clearer picture of what these women have experienced and need in their ongoing battle with the stigma of alcoholism.

Perspective of the Research

Goffman (1963, p. 22) calls AA an association of stigmatized persons which provides a "full doctrine and almost a way of life for their members." This new way of life implies that one be "re-socialized," which in turn implies a process. The process of stigmatization can be traced by use of the perspective of symbolic interaction and labeling theory. In symbolic interactionism, the mind and self are influenced from outside, that is, from society (Mead 1934). Mead argued that the process of acquiring a

"self" begins with language and involves taking the role of particular individuals and what he termed a "generalized other." The opinions and reactions of others are subsequently internalized and reflected upon so that the individual has a self comprised of those internalized opinions. Likewise, "mind" is a process of internalization; thinking is a reflexive process in that a person can interact with herself as well as others. In this manner, what a person thinks and feels about herself are interactional in nature rather than intrinsic in a physical or psychological manner.

Resocialization into the AA tradition is the focus of this study. Alcoholics, as stigmatized persons, have the option of accepting and internalizing the label ascribed to them as part of the negotiation of meanings that takes place in interaction. In fact, great pressure is put on a person by both "normals" and similarly-stigmatized people to "adopt...the right line" (Goffman 1963, p. 123). Goffman (1963, p. 124) goes on to state that the self both groups attempt to ascribe is an alien one:

> In brief, he is told he is like anyone else and that he isn't--although there is little agreement among spokesmen as to how much of each he should claim to be.

The stigmatized person is caught in a dilemma caused by being put in a category that labeling creates. Schur (1971) states that the problem is not that certain behaviors, such as drinking, do not take place, but that labeling these behaviors creates a meaningful context in

which to judge them. In addition, he notes that labeling and stigmatization can take place in the absence of particular behaviors. For example, a person with a label such as alcoholic, schizophrenic, or gambler does not lose the label despite "recovery." Furthermore, the process of labeling occurs when one presents oneself for treatment and counselling (Schur 1971; Simmons 1969). Consequently, the very methods of alleviating the "symptoms" of the problem ensure that the problem exists and add to the pressure of conforming to the dictates of the label.

The disease concept of alcoholism, with its attendant causality, is the perspective most in vogue at the present time. The approach of this paper, however, is non-causal, and defines alcoholism in the manner offered by Rudy (1977, p. 99):

> Alcoholism is a characterization attached to drinkers by others when these others question the drinkers' behavior and when the drinkers lack the power or desire to negotiate another explanation.

In addition, alcoholism will be viewed as a power issue, as suggested by Sandmaier (1980) and Schur (1971). The ways in which both "normal" society and the stigmatized group attempt to influence the drinker's attitudes toward herself is much different from viewing alcoholism as a disease. Understanding where alcoholic women fit into this issue of power is crucial to determining why they may have difficulty in getting the kinds of treatment that they need. While it is likely that heavy consumption of alcohol

over a long period of time will result in deleterious physical consequences, and that certain psychological characteristics appear to be typical of female alcoholics, neither the physiological approach nor the psychological approach results in a clear understanding of the total problem. Both approaches lead to the search for pathology and ignore the fact that drinking alcoholic beverages occurs in the context of <u>society</u>. Studying women who have "dropped out" of AA from a symbolic interactionist and labeling perspective will focus on process and meaning in their lives in an attempt to gain a more complete picture of the problems that they face in combating the stigmatization of alcoholism.

CHAPTER II

LITERATURE REVIEW

The History of Alcoholism Research

American society tolerates drinking, but not excessive drinking, which is viewed as a problem of self-control (Lovald and Neuwirth 1968; Denzin 1987). For women who drink "excessively", the condemnation is even worse. Lender (1986) traces this condemnation to the value America placed on the family in its early history. Since everything American was imbedded in the family, family roles became clearly defined. Alcoholism was also clearly defined, since it threatened the family by leading to irresponsible behavior by the male parent. But since it was the woman who had primary responsiblilty for the family, her drinking was "a form of the most extreme deviance" (Lender 1986, p. 47). Drinking caused women to abandon the caretaking of children and of men. The selfless image attributed her by society was marred, and she was seen as unnatural and inhuman (Sandmaier 1980). Even today, despite the fact that women are "allowed" to drink more, the double standard exists (Sandmaier 1980; Saunders 1980; Gellman 1964).

The disease model of alcoholism became the accepted

way of viewing the problem due to the work of E.M. Jellinek in the forties. He was not the first to propose this model, however; the first documented mention of alcohol as a disease dates back to ancient Egypt (Keller 1986). In the United States, this model was given momentum through the efforts of Dr. Benjamin Rush in the early 1800s (Strug, Priyadarsini, and Hyman 1986). Yet it was Jellinek's model that gained the most importance in the twentieth century. Four phases of alcoholic drinking evolved from his study: prealcoholic, prodomal, crucial, and chronic (Jellinek 1969). Physical and psychological symptoms appear in the second, or prodomal phase, and include blackouts, surreptitious drinking, and feelings of guilt. Characteristics of the crucial phase are loss of control over drinking, the focusing of all behavior on alcohol, social isolation, resentment, poor nutrition, and drinking early in the day. In the chronic phase, the alcoholic has low morale, goes on "benders," will drink anything containing alcohol, and experiences tremors and loss of tolerance to alcohol. While Jellinek's sample was adequate in size, it sampled only <u>male</u> members of Alcoholics Anonymous. Jellinek (1946, p. 5) states that he did not include women in his samples because

> on the one hand the number was too small to be analyzed separately, and on the other hand the data differed so greatly for the two sexes that merging the data was inadvisable.

Rudy (1968, p. 93) states that Jellinek's aim was a working hypothetical model, but that it became the "prototype of

reified alcoholism models."

Jellinek's model is often used partially or metaphorically. For instance, Beider, O'Hagan, and Whiteside (1982) and Keller (1986) find it a useful concept when the alcoholic becomes dependent upon or addicted to alcohol, and the American Medical Association (Kissin "Theory," 1977, p. 1) calls alcoholism "'a complex disease with biological, psychological, and sociological components.'" In the latter definition, the sociological components refer to factors such as employment and marital status rather than to processes such as stigmatization or labeling.

Despite the widespread acceptance of Jellinek's model, there are other disciplines which base their theories of causation on factors besides biology. Psychological theories of causation include McLelland's (1972) power theory and Williams' (1977) dependency theory, as well as theories dealing with personality disorders (Beigel and Ghertner 1977). Other approaches include the behavioral theories/learning theories of Sobell and Sobell (1978) and of Mello (1983), and anthropological approaches such as Bateson's (1972) escape theory, Madsen's (1974) ambivalence theory, and MacAndrew and Edgarton's (1969) "time-out" theory. Apparently the only approach not concerned with alcoholism's causes are the sociological theories that consider alcoholism as part of the entire social context (Beigel and Ghertner 1977). These perspectives view alcoholism as both cause and consequence of

various life stresses and pressures (Wilsnack, Klassen, and Wilsnack 1986).

Overview of Research on Alcoholism and Female Alcoholics

Typologies of alcoholics and of the progression of alcoholism have been attempted many times in research. Most of the alcoholism typologies follow a modified disease model. The emphasis is on the course alcoholism takes, and despite minor disagreements as to <u>when</u> "alcoholism" occurs as opposed to "problem drinking" or "hazardous drinking" (Beider et al. 1982), the typologies are similar. Typical is the Criteria Committee of the National Council on Alcoholism's (1982) version: early stages of alcoholism are signified by tremors, tolerance, and blackouts; intermediate alcoholism involves physical illness, switching drinks in an attempt to control it, and problems with one's family; the final stage includes more physical illness, job and family loss, gulping drinks, and frequent automobile accidents.

Such agreement is not reached by those attempting a typology of <u>alcoholics</u>. Some researchers point to a common theme of denial (Weinberg 1982; Beider et al. 1982; Denzin 1987). Others focus on the criterion that sets alcoholics apart from non-alcoholics: control over drinking (Sandmaier 1980; Denzin 1987; Kissin "Theory," 1977; Wallace 1982). Other feelings apparently common to alcoholics are

fear (Denzin 1987), anxiety (Criteria Committee 1982; Kissin "Theory," 1977), guilt, depression, loneliness, self-hatred, and hopelessness (Wallace 1982). Despite common factors, Kissin ("Theory," 1977) concludes that once alcoholics stop drinking, they are an extremely heterogeneous group. Others see alcoholics as heterogeneous to begin with (Saunders 1980; Seixas 1982).

Since much of the research does not differentiate between men and women, typologies of female alcoholics have also been attempted. As with alcoholics in general, women overall are considered to be psychologically heterogeneous (Horn and Wanberg 1975; L. Gary and R. Gary 1985-86; Beckman 1975; Wilsnack 1976), with a few exceptions. Schuckit and Morrissey (1976) report that women appear to have higher rates of guilt, anxiety, and depression; depression is also noted by Mayer and Black (1974). Low self-esteem is another common finding (Beckman 1975; Saunders 1980), as are feelings of isolation (Haver 1987b; Schilit and Gomberg 1987). Related to women's feelings of low self-esteem are Gomberg's (1982) findings that men tend to bring up issues of aggressivess and grandiosity in treatment and that women do not, and Saunders' (1980) study which showed that women attributed good outcomes to chance and bad outcomes to personal failure, whereas men attributed good outcomes to personal success and bad outcomes to chance.

A look at men's and women's drinking patterns shows

differences that are due to women's different experiences with alcohol (L. Gary and R. Gary 1985-86). These differences are not only gender-related; socioeconomic status also plays a part (Schuckit and Morrissey 1976; Horn and Wanberg 1975), as does ethnicity (L. Gary and R. Gary 1985-86). Despite female alcoholics' heterogeneity, two results turn up frequently in the research. The first is that more women appear to exhibit what is termed "secondary alcoholism," which means that their problems with alcohol are in addition to, or result from, other serious life problems (Saunders 1980; Page 1980; MacDonald 1987). This finding may explain why low self-esteem, common in all alcoholics, is worse in women, since it can both pre-date and result from alcoholism. The second recurrent finding centers on the personal and familial relationships women are experiencing prior to alcoholism and subsequent to its onset. More alcoholic women come from disturbed families than do men (Saunders 1980), and more have present problems with family members (Saunders 1980; Page 1980; Beckman and Amaro 1984-85). These factors may contribute to the results reported above concerning women's feelings of isolation; women's social support networks appear to be inadequate both before and after their problems with alcohol (Schilit and Gomberg 1987).

In summary, while there appear to be many different traits that are exhibited by alcoholics, the traits that recur most often in the research are anxiety, guilt, self-

hatred, depression, and isolation. The major difference between men and women is that women tend to exhibit more of these symptoms. Also, female alcoholics tend to have more problems with relationships and with problems that pre-date alcoholism. Both of these factors are traced to sexism in American culture by some researchers (Saunders 1980; Wolfe 1979; Schilit and Gomberg 1987; Sandmaier 1980). The expectations for women's behavior are different from those of men, both presently and throughout the history of this country. Other researchers ask whether changing role expectations creates confusion for women and plays a part in their alcoholism. Saunders (1980) argues that since women tend to obtain their feelings of self-esteem from outside themselves, changes in gender-related roles may be related to issues of self-esteem. On the other hand, Beckman (1975) relates that sex-role confusion may be common to non-alcoholic women and to men, and points out that determination of sex-role confusion is based on answers to test items rather than to actual confusion.

Alcoholism Rehabilitation Programs

A variety of rehabilitative treatments exist that are based on the models previously discussed. Obviously, these treatments are built upon beliefs that treatment personnel hold about what an alcoholic's needs are in recovery. Two topics will be discussed prior to the particular methods utilized by the models in treatment: treatment goals and

the issue of abstinence. Most health care professionals agree that recovery is an individual choice and effort. Therefore, treatment should be geared toward helping that individual attain what he or she wants (Baekland, Lundwall, and Shanahan 1973; Shore and Kofoed 1984; Weinberg 1982; Underhill 1986). Heinemann and Smith-DiJulio (1982, p. 283) assert that the aim of rehabilitation is the "attainment of the highest level of health possible." Other suggestions beyond this basic goal are broadly-based therapy (Page 1980), short-term therapies (Weinberg 1982), therapies that support and slowly offer insights (Keller 1986), and therapy based on which alcoholic syndrome that the client happens to be in at the time (Pattison 1966). Morgan (1987) and Underhill (1986) point to the different experiences that women face in their lives both in relation to alcohol and in general, and suggest that these differences be taken into account in treatment. To be avoided in treating alcoholics are indiscriminate usage of multiple treatments (Pattison 1966) and "the induction of guilt" (Weinberg 1982, p. 297). Page (1980) suggests that women's resistence to treatment and denial of their problem should not be met with hopelessness by the counselors, although Clemmons (1979) states that resistence and denial are merely labels applied to taciturn alcoholics by frustrated treatment personnel.

The question of abstinence as a treatment goal has been hotly debated throughout the research on alcoholism.

Until recently, the assumed goal was to rid the alcoholic of his or her dependency on alcohol (Clemmons 1979; Shore and Kofoed 1984; Heinemann and Smith-DiJulio 1982). Some researchers agree that this approach is practical for most alcoholics, at least as a short-term goal (Mayer and Black 1974; Weinberg 1982; Galanter "Networks," 1984), but others disagree. They purport that the areas of the alcoholic's life that need adjustment are not affected by the mere cessation of drinking, and that if sobriety is the only goal, limited success will result (Baekland 1977; Pattison 1966; Shore and Kofoed 1984; Nathan and Briddell 1977; Clemmons 1979). As Pattison (1966, p. 56) states, "reasonable goals," rather than automatic abstinence, should be the criteria for successful recovery.

Treatment approaches based on the biological model look for ways to produce physiological changes in the alcoholic (Kissin "Theory", 1977; Pattison 1984). These treatments include drug therapy (Baekland 1977; Mayer and Black 1974) and nutritional therapy (Keller 1986). Keller (1986) claims that most therapies in the field of alcoholism rehabilitation are psychologically-oriented. However, these treatments are also patterned after the disease model of alcoholism (Pattison 1984). Kissin ("Theory," 1977) and Calobrisi (1976) describe such treatment as being based on some underlying psychopathology or personality disorder. The behavioral model, like both the psychological and biological models, focuses on the

individual alcoholic as the locus of necessary change. Techniques used are negative or aversive conditioning (Kissin "Theory," 1977; J. Steffen, V. Steffen, and Nathan 1982), desensitization, biofeedback, and assertion training (Steffen et al. 1982), and rational-emotive therapy (Steffen et al. 1982; Wolfe 1979). Sociological or social theory approaches eschew individual pathology and state that the social setting is an important factor (Kissin "Theory," 1977; Pattison 1984). Furthermore, Shore and Kofoed (1984) state that it is how the community defines the problem that determines what type of treatment one gets, not the person's particular problem.

Treatment settings range from protected environments to out-patient treatments. Examples are therapeutic communities, halfway houses, various types of groups, and family therapy (Beigel and Ghertner 1977; Mayer and Black 1974). Other non-therapeutic settings include education and job counselling (Beigel and Ghertner 1977; Mayer and Black 1974).

With regard to treatment modalities, the cessation of drinking without therapeutic guidance, family therapies, private therapy, and group therapy surface as highest in importance. One-third of all people having problems with alcohol recover on their own, as reported by Bourne and Fox (cited in Heinemann and Smith-DiJulio 1982) and Keller (1986). Naturally, the question arises as to how effective the various treatments really are, since it is possible

that those recovering from alcoholism would do so without any treatment method at all.

Steinglass (1979) explains that family therapy, or family systems therapy, arose from two observations made of patients in private therapy. First, it was noted that, despite progress made by a client in private therapy, her problems resurfaced once she reentered her home environment. Second, it became obvious that versions of home life differed among the individuals comprising a family unit. Consequently, the boundaries of the problems one might have with alcohol are extended to include the entire family, since the entire family system is affected by, and maintains, these problems.

Steinglass (1979) states that, while family systems therapy is not a single set of procedures, all the therapies contained within its framework share several key concepts. The family is viewed as a unit that creates a boundary between itself and the outside world; this unit tends toward balance, even though the balance may entail unhealthy behavior. As stated above, the entire family is considered as "patient," since it is believed that the individual acts as part of the family unit rather than alone. The focii in treatment are communication and the interactional/behavioral context. Four therapies utilizing a family systems approach include conjoint family therapy, multiple-impact therapy, network therapy, and multiple-family therapy (Steinglass 1979). Despite its widespread

popularity, Steinglass (1979) states that little evidence as to its efficacy in treating alcoholism has surfaced, nor have comparisons been made between it and other treatment modalities.

The third modality, private therapy, is deemed by leaders in the field of alcoholism to be virtually ineffective. Galanter and Pattison (1984) report that most alcoholics do not go this route, but both Sandmaier (1980) and Duckert (1987) state that women seek private therapy more often than any other type. The obvious question that this observation raises is why women would seek a type of treatment that is ineffective. The next topic in this section may shed some light on this question.

Brandsma and Pattison (1984) state that group treatment is the dominant treatment modality in alcoholism rehabilitation today, due to AA's success and because of the positive advantages of group settings. Doroff (1977), Rubington (1977), and Keller (1986) concur that group treatment is the best approach. Galanter ("Professionally," 1984) states the advantages of groups: low cost, no permanent authority figure (in self-help groups), the possiblility of development of strong bonds among members, and the fostering of a sense of belonging.

However, other researchers question the efficacy of such groups for women. While Duckert (1987) sees no difference in the success rates of men and women in mixed groups, many others see possible problems. Differences in

topics discussed by men and women in groups are pointed out by Priyadarsini (1986). In his study, he found that men tended to discuss jobs and ways to appropriately vent anger. Priyadarsini also found that women had more trouble talking at all, and when they did, their topics revolved around the difficulties of expressing anger and on affection, manners, and attire. He also states that women yielded to peer pressure more. Gomberg (1982) discovered that men tended to bring up issues of grandiosity as well as aggression. In contrast, these two topics were not concerns of women in the group that she studied. Underhill (1986) discovered that women tended to repeat traditional "feminine" roles in the group setting: they were supportive of the men while the men discussed their own problems. Fox (1979) states that women resist self-disclosure in groups, and Rudy (1986) found that women felt less integrated into the group. Perhaps the feeling of these researchers can be summed up by Page (1980, p. 164):

> Working with alcoholics in groups has been the traditional method of treatment for what was originally an almost entirely male clientele. There has been no clear evidence to demonstrate that this method of help is as appropriate to women as to men and many practitioners have expressed doubts as to its efficacy for women, as a result of their own observations and of comments made by women consumers.

The research cited above may explain why women seek private treatment despite its poor showing as an effective rehabilitation modality. Another possibility is that many referral agencies may have resisted sending women to

traditional alcoholic treatment centers rather than that women themselves resisted going (L. Gary and R. Gary 1985-86). Schuckit and Morrissey (1976) suggest that the recognition of secondary alcoholism in women by psychiatric professionals may have been the reason for such resistance. Yet, the analyses and studies in the above discussion on women and groups adds support to the possibility that women's feelings about group treatment may be the deciding factor. A study by Curlee (1971) found that women and men who were directly asked their preference of treatment modalities in an inpatient program offering a variety of types differed in their responses: men picked group therapy and contact with their fellow patients as the most helpful to them, but women preferred their private interviews with the psychologist.

Stein (1985) argues that none of the treatment modalities or settings have much effect on the problem of alcoholism, because alcoholism is necessary to societal integration. Consequently, alcoholism is misdefined and treatment misdirected, and the alcoholic pays the price. As Stein (1985, p. 196) states:

> We can hardly resolve problems when we are unwittingly committed to their misdefinition, when cultural treatment is itself a form of resistance to treatment that resymbolizes the underlying, shared unconscious conflicts.

Only by examining the underlying normative framework of the culture in which behavior is negotiated will the puzzle of alcohol problems be resolved (Stein 1985).

A Short History of Alcoholics Anonymous

According to the 1985 edition of Alcoholics Anonymous' major publication (Wilson 1985), there are an estimated one million members of AA in 114 countries. One-third of the membership is female. Shaw (1980) asserts that the numbers of female members increased during the 1970s, but Gellman thought that women were over-represented in AA in comparison to the total population when his book was published in 1964. Conflicting reports of membership may be due to the fact that no strict rules for membership exist: a person is a member if she says she is (Gellman 1964; Leach and Norris 1977). Obviously, then, a person can be a member without attending a meeting or working on the program. Despite the uncertainty of membership, Baekland and Lundwall (1977) state that the AA program alone treats half of all alcoholics who seek treatment; all other treatments combined serve the other half.

The philosophy of the AA program is derived from two ideological bases: science and religion. From science are derived physical and psychological disease explanations of alcoholism (Rudy 1986; Kurtz 1980). From religion evolves moral explanations (Rudy 1986; Kurtz 1980), with its themes of limitation and hopelessness, and acceptance of limitation and need for conversion (Kurtz 1980). The religious roots of AA began in colonial America. Kurtz and Kurtz (1985) state that, while alcohol consumption was tolerated

in these early times, drunkenness was not. Such misuse took away free will, a notion of supreme importance to Puritan founders. Furthermore, drunkenness disrupted community life in a manner threatening to the fledgling colonies. These two consequences led to a belief by religious forces that alcoholism was a personal moral failure.

By the late 18th century, secularization had affected the country's attitudes toward drinking. Dr. Benjamin Rush became the leading spokesperson for the disease concept of alcoholism beginning in 1784. However, the earlier moral issues of alcoholism were not entirely supplanted by this medical model. Rush himself, having been converted to a belief in earthly universal salvation (Hawke 1971), combined the scientific and moral realms in his writings. For example, Rush's 1814 publication on alcohol exhorts America's ministers to aid him in saving "our fellow-men from being destroyed by the great destroyer of their lives and souls" (Rush 1981, p. 26). Furthermore, Rush (1981, p. 31) advocated "a practical belief in the doctrines of the Christian religion" as a cure for the disease of alcoholism.

Two other influences incorporated in AA's philosophy were the Temperance Movement and the rise of the public health model. Some of the moral demands of the former were adopted, although not its belief that alcoholism was not an addiction (Kurtz and Kurtz 1985). The public health model

arose from the scientific/medical paradigm, and proposed a public sharing of responsibility for the problem of alcoholism.

The objective/subjective mixture utilized by AA conforms to a type of knowledge system described by Lutke (1989) as neo-esoteric. The combination of scientific and religious ideologies in AA is an uneasy one, yet AA's founders believed the mixture necessary for the program's success. In AA, alcoholism is defined as a three-fold malady encompassing the biological, psychological, and spiritual realms of a person's behavior (Kurtz 1980). According to Wilson (1957, p. 13), it is

> "the obsession of the mind" that compels us to drink "and the allergy of the body" that condemns us to go mad or die.

While the disease approach focuses on the alcohol, AA's use of this model ends up with a somewhat different focus. Despite the biological, or involuntary, nature of alcoholism, the moral decisions that an individual makes regarding her disease can affect and change its course.

AA began with two founding members, William Griffith Wilson and Dr. Robert Holbrook Smith, on June 10, 1935, which is the date of Smith's last drink (Kurtz 1980). Kurtz (1980, p. 33) lists several other "founding moments" prior to that summer which are important in understanding AA's development. Wilson, principal author of AA's most important manuscript, the "Big Book," relates that he became convinced of alcoholism's disease nature while in

the hospital for that reason. The attending physician, neuro-psychiatrist William Duncan Silkworth, defined alcoholism as an allergy, an illness, and an obsession (Kurtz 1980). Wilson (1985) reports that during his recuperation, he was visited by a friend who had had a religious experience due to his membership in the Oxford Group. Wilson followed this revelation with a religious experience of his own, and after being released from the hospital, he joined the Oxford Group himself (Kurtz 1980).

Kurtz (1980) relates that the Oxford Group was a non-denominational group founded early in the century by conservative Lutheran Frank Buchman. His influences were traditional Protestantism and the evangelical revivalism of Dwight Moody. Buchman's goal was to revive primitive Christianity, and he developed Four Absolutes to this end: honesty, purity, selflessness, and love. Kurtz (1980, p. 9) states that Wilson was wary of religion and absolutes, but that he liked the Group's practices of "self-survey, confession, restitution, and the giving of oneself in service to others." Wilson would later incorporate these practices into the Twelve Steps of AA. Wilson rejected other elements of the Oxford Group that he did not think would work for alcoholics: the exclusivity of the group and lack of anonymity. Wilson had in mind the experience of the Washingtonians, a nineteenth-century alcoholic self-help group that was successful until its members became politically involved: their lack of subsequent anonymity

signalled the dissolution of the group (Rudy 1986). Nonetheless, Wilson used what he could of the Oxford Group for his own sobriety, and took fellow alcoholics to its meetings until AA was formed in the late 30's and fellowship in it was a sufficient means of cohesiveness (Kurtz 1980). Kurtz states that it had been Wilson's series of meetings with Smith that had prompted Smith to quit drinking on June 10, 1935, and the importance of that date is that the two realized that the bonds between alcoholics could work to everyone's advantage in achieving sobriety.

Once AA was started, Wilson, Smith, and the new members initiated the writing of Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered From Alcoholism. It is still known by its early euphemism, the "Big Book," alluding to the bulky economical paper it was originally printed on in 1939 (Kurtz 1980). There are two major sections to the book: the first section describes AA's philosophy and program, and includes Wilson's story and the Twelve Steps and Twelve Traditions. The second section, which comprises two-thirds of the book, contains personal stories (beginning with Smith's) of alcoholics who recovered in AA. Wilson's influence on the writing of the Big Book was enormous; Kurtz (1980, p. 59) states that he was a "self-confessed extremist," and that he had strong promotional instincts, especially as compared to Smith. Kurtz also describes him as thriving on dissen-

sion and controversy, and that his emotions tended to vary considerably. On the other hand, the importance of the task at hand caused him to go to great pains to not alienate any outside group, and he ended his exploration of Catholicism not only because of dogmatic disagreements but because he did not want identification problems to arise. In the mid-1940s, he became very aware of his grandiosity and controlling influence over the group, and began to retreat.

Gellman (1964) states that when Wilson and Smith first began organizing the group, they had sought donations from the wealthy private sector, and especially J.D. Rockefeller. While Rockefeller refused to subsidize the group itself, he gave Smith and Wilson a small weekly stipend to allay their deep financial woes. When Wilson officially withdrew from the leadership of his organization in 1955, AA was entirely self-supporting (Kurtz 1980). Smith died in 1950, and Wilson in 1971 (Leach and Norris 1977).

According to Kurtz (1980), factions exist in AA today, most notably between mainstream members and members who desire to make AA more religious than it is. To date, AA's major publications remain as they were written, except for the addition of stories in the second section of the Big Book.

Organizational Structure of AA

Despite the autonomy that each local chapter enjoys, structure does exist at many levels in AA. Gellman's look at the organizational hierarchy in 1964 is not outdated, for, like the primary source of AA philosophy, the Big Book, this structure has remained unchanged over the years.

At the highest level is the General Service Board, which contains the Board of Trustees. The Board contains elected members from the local groups as well as non-AA members. This voluntary group is responsible for domestic and international public relations, the maintenance of AA traditions and standards in the published materials, and the overseeing of AA operational funds.

The General Service Headquarters, located in New York City, takes care of the day-to-day operations of the organization, under the guidance of the General Service Board. Public relations are also handled here, along with responses to personal communications and inquiries. Publishing a directory of AA groups and organizing the annual General Service Conference are two other activities that the Headquarters coordinates. Two publishing agencies handle AA's copyrighted material. Alcoholics Anonymous Publishing, Inc. prints AA's books and pamphlets, while Alcoholics Anonymous Grapevine, Inc., takes care of their monthly journal.

Structure also exists at the local level, despite the fact that AA has no written constitution. Rotating posi-

tions in each group include steering committee members, chairman, treasurer, secretary, program chairman, inter-group delegate and alternate, institutions representative, and General Service representative. These positions are obtained either by election or appointment and are held from six months to two years. The work involved in these positions includes decisions on where, when, and how often to hold meetings, collection of donations and paying of bills, setting up tables, chairs, and refreshments for meetings, organizing talks at various institutions, and selecting speakers for the meetings.

Open and closed meetings are the two primary types of gatherings. No attendance or minutes are recorded, but each meeting opens and closes in a pre-determined way and is the same for all local groups. Any community member may attend an open meeting, during which one or two AA members retell their personal stories. Closed meetings are for AA members only, and revolve around discussion and study of the Big Book and Twelve Steps. Two other types of meetings are optional beginner's meetings and institution meetings. Beginner's meetings are orientations which are held for new members before a regular session. The visitation of persons in need of help or institutions are the topics of discussion in institution meetings.

Autonomy by local AA chapters is exhibited by flexibility of scheduling. That is, the number of meetings held per day and per week, and decisions about when to

schedule open and closed meetings vary from group to group. In addition, no outside influence is exerted during the local election process. Yet the structure of each AA group is similar enough that members of one local chapter can participate in another with little discomfort. By keeping the framework of each local group the same, AA offers its members the benefits of continuity and a sense of belonging.

AA as a Treatment Program for Alcoholics

Attempting to create typologies of AA members has met with varying degrees of success. Socioeconomic factors most successfully define a pattern. Mayer and Black (1974) state that it is the well-functioning members of the middle class who are most attracted to AA, because AA's structure is most similar to their own lives. In agreement with Mayer and Black are Leach and Norris (1977), Baekland and Lundwall (1977), and Kurtz (1980). Psychological traits of AA members, like the traits for alcoholics in general, are varied. Social dependence, guilt, obssessive-compulsiveness, ability to verbalize (Baekland and Lundwall 1977), alienation, isolation, and responsiveness to peer pressure (Kissin "Medical," 1977) typify the membership, according to some researchers. Denzin (1987) asserts that the AA alcoholic is in Jellinek's "crucial" phase of drinking, meaning primarily that he or she has experienced loss of control over drinking.

How AA typologizes alcoholics and alcoholism is important in understanding how their program works. At the center of AA's philosophy is the belief that alcoholics suffer from "self-will run riot" (Wilson 1985, p. 62). This theme of selfishness and self-centeredness appears in many places in the Big Book (for example, Wilson 1985, pp. 60-62, 64, 127, 133), although it is sometimes replaced by the more psychological term of "egocentricity" (Wilson 1985; Kurtz 1980). This selfishness is also called pride, alcoholic grandiosity, or the "First Cause" of alcoholism (Kurtz 1980, p. 95). Egocentricity is viewed as a sign of immaturity, and must consequently be changed (Kurtz 1980). Denzin (1987) describes the change as a shattering of the ego, which is sometimes brought about quickly through a conversion experience similar to the one Wilson himself experienced in the late 1930s.

In AA's view, the next major symptom linking all alcoholics is denial. In Kurtz's (1980) explanation, alcoholics deny their alcoholism, which, to AA, is a denial of reality. Since AA's reality includes God, it is also a denial of God. What the alcoholic is left with is herself, and the replacement of God with the self is the ultimate in self-centeredness. What AA requires to combat this self-centeredness is rigorous honesty, which involves the admission of one's own personal powerlessness over alcohol (Wilson 1985).

Other key features of an alcoholic are resentment,

jealousy, envy, frustration, fear, obstinacy, and sensitivity (Wilson 1985). Despite the fact that non-alcoholics also suffer from these feelings, Wilson held that alcoholics were different from non-alcoholics. He states (Wilson 1985, p. 30) that the "delusion that we are like other people, or presently may be, has to be smashed."

AA's model of alcoholism is, of course, Jellinek's disease or phase model, at least in essence. Wilson (1985) preferred to speak of alcoholism as an allergy, an illness, or a malady, rather than purely a disease entity (Kurtz 1980). Believing that alcoholism is a three-fold malady--physical, psychological, and spiritual (Kurtz 1980)--allows the alcoholic to feel less burdened of the responsibility of becoming an alcoholic and to thus start the AA program (Rudy 1986). Contradictorally, once the alcoholic is into the program, he or she is made to believe that the cause of alcoholism was his or her own doing. An example of utilization of the phase model is the occurrence of blackouts. These occurrences are related to AA's beliefs about denial; if a member reports no occurrences of blackouts, he or she is assumed to be denying reality, since every "true" alcoholic experiences them (Rudy 1986).

Besides the occurrences of blackouts, another "inevitable" is that no amount of sobriety ever makes an alcoholic immune to his or her disease (Wilson 1985). Denzin (1987) claims that AA believes that an alcoholic will almost always drink after attending the first or

second AA meeting. AA also believes that the alcoholic's family comes second to the alcoholic's membership in AA (Rudy 1986), and that it is only another alcoholic who can successfully influence someone who has lost control over his or her drinking (Wilson 1985). AA mistrusts intellectualism and professionalism and puts its faith in the "common man" (Kurtz 1980), although this seems contradictory in light of the fact that most middle class people are fairly well-educated. However, AA's reasons for forming initially were due to lack of help from the traditional helping disciplines; therefore, the distrust is more easily understood (Wilson 1985).

The issue of control is central to AA's definition of alcoholism, and explains their belief that complete abstinence is essential for recovery. While Wilson (1985) admitted that control may be regained early in one's drinking career, he believed that a true alcoholic is not likely to desire such control at that time. Since loss of control is <u>the</u> sign of alcoholism, avoiding that first drink is the answer (Wilson 1985; Kurtz 1980; Rudy 1986). Abstinence is the closest to an absolute that AA contains (Kurtz 1980), although Leach and Norris (1977) claim that abstinence is a <u>goal</u> in AA rather than a requirement.

The Big Book outlines AA's philosopy about alcoholics and alcoholism, although it is the Twelve Step program that sees these beliefs put into practice. As has been stated earlier, Wilson was wary of religious dogma; Kurtz (1980,

p. 52) reports that what bothered Wilson the most about organized religion was "'how confoundedly right'" they claimed to be. Consequently, Wilson included disclaimers in the Big Book as to AA's suitability for everyone (Wilson 1985; Kurtz 1980; Denzin 1987). Yet Wilson and Smith's belief that they finally could offer alcoholics a program that would work caused them to state often that failure to achieve recovery was the result of lack of individual effort rather than the fault of the program. As the Big Book (Wilson 1985, p. 58) posits near the beginning:

> Rarely have we seen a person fail who has thoroughly followed our path. Those who do not recover are people who cannot or will not completely give themselves to this simple program, usually men and women who are constitutionally incapable of being honest with themselves....Their chances are less than average.

Kurtz (1980) reports that the use of the word "rarely" in this quotation was deliberate: although Wilson wanted to use the word "never," pressure by the group forced him to change his mind. Nonetheless, this non-absolute word is followed by strong language that indicates that the program itself should not be faulted in case of personal failure.

Denzin (1987) refers to the AA program at various times as a transformation of the self, a socialization process, a conversion, and a commitment to a new way of life. Phases in recovery include hitting bottom, seeking help in AA, admitting one's alcoholism in AA, "slipping," becoming a regular member, and learning the program. Rudy (1986, p. 21) also looks at the program as a process, with

steps of "hitting bottom, first stepping, making a commitment, accepting one's problem, telling one's story, and doing twelfth-step work." Other elements in this process are inclusion of significant others in similar programs such as Al-Anon (Rudy 1986), finding a balance in one's life, and eating sweets to maintain physiological equilibrium (Wilson 1985).

The process described above is made possible when the alcoholic follows the Twelve Step Program (see Appendix). Stafford (1979, p. 257) analyzes the steps into the categories of "surrender, alliance with a Higher Power, settling with the past, self-analysis, maintenance of a good spiritual condition, and working with others." Kurtz (1980) shortens this list to the core topics of hopelessness, deflation, conversion, and interaction with others. Steps 1-3 cover the first three topics on his list, and Steps 4-10 are linked by the honesty they require. Further analysis of the steps reveals their therapeutic value. Leach and Norris (1977) find Step 3 to be crucial since the alcoholics turn their recovery over to someone or something else in admission of their powerlessness over alcohol. The Big Book (Wilson 1985) explains that the testimonial nature of Step 5 teaches humility, fearlessness, and honesty, and that Step 11 helps lessen egocentricity by fostering a healthy dependency on a Higher Power. Denzin (1987) points out that Steps 1, 4, 8, and 9 are the only ones without a spiritual reference, and it is

this topic that will be turned to next.

From AA's inception, a major criticism has been that it is more a religion than an alcoholism recovery program. Early negative publicity by Liberty, a general interest weekly magazine originating from New York and Chicago, resulted in potential members shying away (Kurtz 1980). Kurtz reveals that when the Big Book was written in 1939, AA members felt that there was too much "God" in it; consequently, the phrase "as we know Him" was added, along with the euphemism "Higher Power." They had recognized that they might lose potential members and sought to placate both religous and non-religious people. Yet, because of AA's strong belief that alcoholism is primarily a spiritual malady, many references to God (including euphemisms) remain in the Big Book and Twelve Steps. In a concordance of the Big Book authored by an anonymous AA member (Stewart C. 1986), faith is listed 11 times, spiritual help 7 times, prayer and meditation 43 times, pronouns for God 80 times, and God 132 times. Kurtz (1980) suggests that the distinction should not be made between "spiritual" and "religious," but between "religious" and "churchy;" that is, AA offered alcoholics its own alternative to organized religion since the denominations had failed to help them.

Perhaps the question of whether AA is a religion or a spiritual program or a new denomination can be best answered by simply stating what it is not: secular. Examples of AA's thoughts on spirituality as necessary for

recovery are as follows: "Every day is a day when we must carry the vision of God's will into all of our activities" (Wilson 1985, p. 85), "there was nothing left for us but to pick up the simple list of spiritual tools laid at our feet" (Wilson 1985, p. 25), and this exhortation (Wilson 1985, p. 58-59):

> Remember that we deal with alcohol--cunning, baffling, powerful! Without help it is too much for us. But there is One who has all power--that One is God. May you find Him now!

Loss of control over one's drinking means that only by turning to a "power greater than themselves" can the alcoholic hope to recover (Wilson 1985).

Gellman (1964, p. 30) states that

> there are few professed atheists in A.A. The individual who disagrees with such points of view learns to modify his position or remains silent in his dissent.

Kurtz (1980) relates that AA believes that agnostics and atheists do not long keep their beliefs once they join AA. AA asserts that the alcoholic's Higher Power need not be spiritual in nature (Gellman 1964), but pressure to create a spiritual life is strong once an alcoholic joins the program. In a chapter written by "former" atheists and agnostics, the choice offered to the alcoholic is the hopelessness of continued drinking or a spiritual life. The authors of this chapter (Wilson 1985, p. 44), sensing that a non-religious person might be dismayed by the choice, respond with: "but cheer up, something like half of us thought we were atheists or agnostics." Further in

the chapter, they state (Wilson 1985, p 49):

> Instead of regarding ourselves as intelligent agents, spearheads of God's ever advancing Creation, we agnostics and atheists chose to believe that our human intelligence was the last word, the alpha and the omega, the beginning and end of all. Rather vain of us, wasn't it?

Time after time, the Big Book states that without spirituality, the alcoholic is doomed to failure (for example, Wilson 1985, pp. 14, 15, 27, 34, 177). Perhaps the strongest statement against secularism is found in Smith's story in the second section of the Big Book. He states (Wilson, 1985, p. 181):

> If you think you are an atheist, agnostic, or skeptic, or have any other form of intellectual pride which keeps you from accepting what is in this book, I feel sorry for you. If you still think you are strong enough to beat the game alone, that is your affair. But if you really and truly want to quit drinking liquor for good and all, and sincerely feel that you must have some help, we know that we have the answer for you. It never fails, if you go about it with one half the zeal you have been in the habit of showing when you were getting another drink. Your Heavenly Father will never let you down!

Incorporating the Twelve Steps guarantees success, and the changes that take place in the alcoholic's life are numerous. The selfishness exhibited by all alcoholics is changed to a healthy focus on achieving sobriety (Kurtz 1980). Admitting weakness and powerlessness creates strength, because the alcoholic affirms his or her humanity by recognizing limitations (Rudy 1986; Kurtz 1980). Guilt is replaced with a mature sense of responsibility (Kurtz 1980; Denzin 1987). While one's recovery is never depen-

dent on others (Wilson 1985), dependence on the program and the fellowship it provides is not only allowed, but considered proper (Kurtz 1980). Honesty, humility, and commitment are further signs of successful rehabilitation, and the meaning of life is no longer found in selfish pursuits, but in giving to others (Kurtz 1980; Wilson 1985; Rudy 1986).

In the final analysis, AA desires the alcoholic's happiness. The Big Book (Wilson 1985, pp. 132, 133) states: "We absolutely insist on enjoying life," and "We are sure God wants us to be happy, joyous, and free." AA remains certain that it has the key to that happiness in its special program of recovery.

Critiques of Alcoholism Research, Female Alcoholics, and Alcoholics Anonymous

A number of the critiques in the research on the topics in this section revolve around sampling and other methodological problems. Miller, Pokorny, Valles, and Cleveland (1970) consider case loss to be the most serious technical problem. Their three-tiered analysis begins with the problem of defining alcoholism: since various definitions exist, it is difficult to describe the population to study. On the second level, problems of representation arise: not every member of the alcoholic population seeks help. Thirdly, of those who do seek help, not all complete the program they have entered, which results in case loss.

Beckman and Amaro (1984-85) and Gomberg (1982) also point to omissions in the samples that could possibly result in misleading generalizations. Gomberg reports that survey data and clinical reports are the primary means of gathering data about alcoholics; her implication is that other means should be utilized in addition to these two, although she makes no specific suggestions. Another methodological problem mentioned in the literature is the lack of a control group for various comparative studies (Schuckit and Morrissey 1976; Wilsnack 1976).

Beckman (1975) bemoans the sparse literature on comparisons of treatment modalities for women, although Pattison (1966) considers such comparisons to be difficult since different programs work for different people. Stafford (1979) takes issue with self-reports: what people <u>say</u> may not be how they <u>act</u>. Taylor and St. Pierre (1986) cite ommissions of relevant topics (such as prevention and social drinking) as a reason for the gaps in the understanding of alcoholism.

Brissett takes issue with the concept of denial as one of the major symptoms of alcoholism and of its use as the centerpiece in alcohol rehabilitation. He argues (Brissett, p. 9) that alcoholic denial is "a difference of opinion concerning the reality of a drinker's comportment and its consequences;" in other words, a person is accused of denial when others see the drinker's version of her behavior or reality as different from their own. Brissett

notes that denial is a negotiable part of everyday life, but the power of negotiation is on the side of the non-drinker when the issue is alcoholism. When the drinker stops denying and admits her alcoholism, she is accepting others' opinions of herself and is embarrassedly apologizing and admitting that others know her better than she knows herself.

Rudy (1986) and Wilsnack et al. (1986) suggest that research on alcoholic behavior is the wrong direction to take, since such behavior can fluctuate dramatically throughout the course of a drinking career, and because these behaviors are not simply the result of alcohol consumption. One direction to take is outlined by Gomberg (1982, p. 218), who states that "One thing is certain: the consequences of alcoholic drinking vary for men and for women." She also asserts that these consequences occur in the personal realm rather than the institutional realm experienced mostly by men (Gomberg 1982; Gomberg 1979). Saunders (1980) suggests a look at socialization processes, since society's expectations for women influence its reactions to them and create the differing consequences. Gomberg (1979) also suggests that class should be scrutinized more carefully in discussions of consequences, since it appears that lower class women receive "worse" public consequences, while upper class women are punished more within the family. Obviously, then, comparisons of consequences should be made between different groups of

women as well as between women and men.

The comparisons among treatment modalities that do exist are decidedly mixed. Miller et al. (1970) estimate that 95% of all alcoholics never reach treatment. Of the five percent that do enter treatment programs, up to 75% drop out before the fourth session (Baekland and Lundwall 1977). Most types of treatments that reach the remaining 25% successfully rehabilitate about four out of ten alcoholics (Baekland 1977; Lender 1986). According to Gomberg (1982) and Fitzgerald, Pasewark, and Clark (1971), comparisons between men and women also result in equal success rates, but L. Gary and R. Gary (1985-86) submit that treatment services are inadequate for women. Smith (1985) asserts that women in AA do better than those not in AA.

Calobrisi (1976) points out that one of the problems with comparisons of services is the definition of "successful" rehabilitation. He (Calobrisi 1976, p. 156) contends that if success included "drinking with a low level of impairment," rates would increase. A study by Haver (1987a) includes this definition. This study also showed that the "successful" drinkers attributed their well-being more to positive life situations in the present than to the treatment itself. In an earlier study, Haver (1986a, p. 108) pointed out that "tolerant, stable, and likeable" therapists who made it clear to clients that they were available for future crises were the major contributing

factors in the women's ability to make changes in their lives. Obviously, then, success can be attributed to a variety of factors.

Many other suggestions have been made concerning better treatment for women besides a redefinition of what constitutes successful rehabilitation. Sociocultural factors such as race, class, education, and family issues should be addressed to enable women to create positive life changes (L. Gary and R. Gary 1985-86; Underhill 1986; Sandmaier 1980). All-women groups have been suggested so that women will have a setting in which to examine their role behavior more easily and so that special issues, such as sexual abuse, may be addressed in a non-threatening setting (Sandmaier 1980; Underhill 1986; Page 1980; Fox 1979). Conversely, Shore and Kofoed (1984) caution against indiscriminate usage of all-female settings simply because, under circumstances other than the ones outlined above, they may be unnecessary. Socialization processes such as learned helplessness, lack of assertiveness, and self-image should be special topics to be covered in therapy (Underhill 1986). Couples groups, systems therapy and use of female counselors have also been suggested (Page 1980; Haver 1987b; Calobrisi 1976).

Many critiques of the AA program exist. It has been called a socialization process and organizational therapy (Gellman 1964; Kurtz 1980; Kissin "Theory," 1977). Its religious elements have been pointed out (Wilson 1985;

Kurtz 1980; Denzin 1987; Gellman 1964; Kissin "Medical," 1977); Chavetz and Demone (1969, p. 267) call it a "large evangelical movement." Favorable assessments include a nod toward the positive aspects of AA fellowship (Kissin "Theory," 1977; Beigel and Ghertner 1977; Gellman 1964; Curlee-Salisbury 1982) and dependence on the group (Rudy 1986; Kissin "Theory," 1977; Leach and Norris 1977). Vulnerability and fragility are seen as positive values to instill, since the sense of limitation that results starts the alcoholic on the road to recovery (Rudy 1986; Mayer and Black 1974; Denzin 1987). AA's pragmatism (Kurtz 1980), anti-intellectualism (Doroff 1977), co-ed makeup (Gellman 1964), and leaderlessness (Page 1980) are also seen as points in its favor. As to the charge that AA refuses to recognize the value of other treatment modalities, both Kissin ("Theory," 1977) and Rudy (1986) see signs that AA is becoming more tolerant of alternatives to getting sober, although this may not really signify a change in philosphy, since AA does not offer a prescription for achieving sobriety, but maintaining it.

Rudy (1986) admits that AA does not work for everyone, even though most AA members believe that their way is the only way. But he (Rudy 1986, p. 93) does not fault them for this belief, as it "is consistent with the views of clinicians everywhere." Kissin ("Theory," 1977) strongly urges that AA should be offered to all alcoholics because of the many positive aspects of its program.

One of the major problems with AA is its self-reported success rate. Their 60-75% success rate cannot be proven (Leach and Norris 1977; Gellman 1964; Rudy 1986), and even the 34.6% success rate reported from a study done by an AA member may be misleading, since many groups (such as low-income and the non-religious) were not represented in the sample (Baekland 1977). Tournier (1979) suggests that correcting that sampling bias may drop its success rate to as low as 5%, and Baekland and Lundwall (1977) cite AA's large dropout rate as further evidence of misleading success rates.

Another key problem is the issue of dependence. Lovald and Neuwirth (1968) state that AA institutionalizes dependency on others. Both Rudy (1986) and Kurtz (1980) mention that the cost of fellowship is loss of autonomy and individuality. AA considers dependence on God or the program (which can be chosen as one's Higher Power) to be the "proper" kind of dependence, yet Kurtz (1980) and Calobrisi (1976) point out that secular belief holds that <u>independence</u> is a worthwhile therapeutic goal.

Chavetz and Demone (1969, p. 271-272) charge that

> By action and by rules, AA expresses more interest in strengthening and perpetuating Alcoholics Anonymous than in helping alcoholics.

The researchers claim that proof of their statement can be seen by AA's unwillingness to help members who do not succeed in their program to seek other types of treatments. Pattison (1966) also cites AA's antagonism toward those who

fail. Related to this charge is Gellman's (1964, p. 121) observation that "members of AA who have achieved a degree of sobriety consider themselves experts on the subject of alcoholism." Since this expertise was gained through membership in AA, the program itself is highly valued and should be perpetuated.

Tournier (1979) criticizes the permeation of AA ideology into the secular, medical, and psychological disciplines. This ideology is not helpful to early-stage problem drinkers because of the emphasis on one's powerlessness over alcohol; Tournier states that in the early stages, the alcoholic does maintain a degree of control over his or her drinking. He also questions AA's insistence that all alcoholics are similar. Other issues are AA's confrontive style (Baekland 1977), and their lack of adequate coping mechanisms for stress (Wolfe 1979).

Some of the criticisms of AA focus on the Big Book. Chavetz and Demone (1969, p. 265) consider the Twelve Steps to be "possibly overdramatized." Kurtz (1980, p. 92) cites one review of that publication as saying it was sacred and terribly out of date, while another likened it to "'a rambling sort of camp-meeting.'"

In reference to women and AA, Priyadarsini (1986) finds females to be more accepting of the program and of the disease concept of alcoholism than are men, and Haver (1986b) counts AA as a predictor of favorable treatment outcomes in women. Gellman (1964) states unequivocally

that AA is good for women because they are no longer rejected or deemed inadequate. In addition (Gellman 1964, p. 79),

> Her status as a female is enhanced and supported. She is not the object of degradation or exploitation and begins to interact with male members with more ease and assurance.

On the other hand, Stafford (1979) suggests that the women who succeed in AA may be quite different from those who do not succeed. She also asserts that women who <u>are</u> in AA feel more at ease and identify more readily in all-women groups. Sandmaier (1980) and Sheehan and Watson (1980) concur with Stafford that women do not feel as comfortable in mixed groups in AA. An additional reason for AA's inappropriateness for some women may be that their belief in sobriety as the genesis of all good feelings leads to their discouragement of other means of alleviating the depression that is so common among women alcoholics (Stafford 1979). Chavetz and Demone (1969, p. 271) claim that a reason for failure in the program may be because AA asks alcoholics to be other-oriented, and many have "nothing to give." Sandmaier (1980) points to a possible socioeconomic reason: AA advocates ninety meetings in ninety days, but single and/or low-income women with children often have difficulty fulfilling that requirement. Curlee (1971) concludes that low success rates among women may simply indicate that something besides AA may be needed.

A common feeling is that AA succeeds where psycholog-

ical treatments have failed (Gellman 1964; Kurtz 1980; Chavetz and Demone 1969). Chavetz and Demone (1969, p. 269) state that

> because we [the psychological professions] failed the alcoholic, AA came into being. An invention does not occur when there is no necessity.

However, this "failure" of psychology may have led to an overabundance of certainty on AA's part. As Gellman (1964, p. 121) puts it:

> Psychiatry, as a discipline, is considered incapable of coping with alcoholism. However, when an alcoholic attempts recovery in A.A. and fails, the burden of responsibility is shifted to the individual and the program itself remains inviolate.

Categorization on the part of psychology has led to its failure to help alcoholics (Kurtz 1980). But AA presents its own set of labels to be applied based on its definitions of alcoholism and its beliefs and assumptions about alcoholics. How women who are labeled as alcoholics do or do not incorporate AA's ideology is important for the further development of research on alcoholism.

Summary

A review of the history of alcoholism research shows that a double standard has existed for women who drink, and that this double standard still exerts its influence today. The disease model of alcoholism dominates research at the present time, despite the fact that early research that led up to the widespread acceptance of this model excluded

women in its samples. While the disease model is the most prevalent, other causal models from non-medical disciplines exist, such as power and dependency theories, personality disorder approaches, and escape and ambivalence theories.

Research on the phases of alcoholism follows a modified disease model. Typologies of alcoholics have been attempted, with the most recurring traits emerging from the research listed as denial, loss of control over one's drinking, fear, anxiety, guilt, depression, loneliness, low self-esteem, and hopelessness. Not all researchers agree that alcoholics comprise a homogeneous group, however. Typologies of alcoholic women turn up characteristics similar to alcoholics in general, although it has been argued that women have <u>higher</u> rates of certain of these characteristics than do male alcoholics. In particular, women seem to exhibit more guilt, anxiety, depression, low self-esteem, and isolation. In addition, women appear to be secondary alcoholics to a greater degree than men, and to be experiencing negative relationships in addition to their problems with alcohol. Some researchers have argued that these differences in women may be attributed to sexism in American culture.

Alcoholism rehabilitation treatments vary, depending on the disciplinary approach and the differing goals of these disciplines. Biological models attempt physiological changes, while psychological models search for underlying psychopathology. Behavioral models attempt to change the

alcoholic through negative or aversive conditioning. All three of these models consider the alcoholic as the locus of the necessary change. Conversely, social/sociological models tend to focus attention on the setting or context of the alcoholic behavior, rather than on the alcoholic.

Ways in which the "problem" of drinking is solved may be one of four: non-assisted abstinence, private therapy, group therapy, and family therapy. While the latter two modalities are most prevalent, non-assisted abstinence accounts for perhaps one-third of all treatment success, and private therapy, as opposed to group therapy, seems to be favored by many women. Women's problems with groups revolve around several issues. Their topics of concern appear to be different from male members of groups. Also, women tend to have trouble talking in groups and expressing their feelings. Finally, women perform in traditional and non-assertive ways when in group settings with men.

A examination of the history of Alcoholics Anonymous reveals that two prevailing ideologies coalesce into the AA philosophy, and are evidenced in AA literature such as the Big Book and the Twelve Steps. This neo-esoteric system of knowledge combines science with religion, resulting in a philosophy that on the one hand seeks to remove the stigma of alcoholism from the individual exhibiting it by defining it as a disease, while on the other hand states that the individual not only is responsible for the disease but has the power to change its course by changing his or her

behavior. The influence of the Oxford Group on co-founder Bill Wilson's thought furthered the scientific/spiritual combination, as shown in Wilson's definition of alcoholism as a three-fold malady: physical, psychological, and spiritual.

AA has designed its own typology of alcoholics. These traits include an over-inflated ego, selfishness, alcoholic grandiosity, denial, resentfulness, jealousy, enviousness, frustration, fear, obstinacy, and sensitivity. AA posits that alcoholics are not like other people, and consequently need the program that AA provides to enable them to live without alcohol. The cornerstone upon which the program rests is the Twelve Steps, with its themes of surrender of control, interaction and fellowship with others, development of spirituality, and admittance of one's faults and of alcoholism. Assessments of Alcoholics Anonymous show that the majority of members are from the well-functioning middle class, and that the program involves a transformation of self, or resocialization process.

Critiques of alcoholism research outline definitional problems that hamper professional decisions of which drinkers need help in the first place, and, once in treatment, what constitutes successful treatment. Other critiques point to the huge dropout rates of most programs, to the questionable success rates of the various programs, and to the lack of use of control groups in many alcoholism

studies. Questioned also is the very focus of research on alcoholism. Some researchers claim that knowledge of the behavior of the alcoholic is crucial in understanding the problem, while others opt for a focus on the consequences of drinking. Other suggestions as to the direction research should take include focusing on societal expectations or on class structures.

Finally, assessments of Alcoholics Anonymous point to its success rates, although other studies claim that these rates cannot be known, since no attendance records are kept. Despite the multitude of studies pointing out the benefits of treatment through AA, the program is not without its detractors. Possible problems discussed in the literature include AA's high religiosity (while purporting to be a therapeutic treatment program), its process of resocialization, its fostering of dependency on the group, and its inapplicability for women who have problems with group settings.

CHAPTER III

RESEARCH METHODOLOGY

Choice of a theoretical perspective in research implies a particular methodology. As Schur (1971) has pointed out, labeling theory lends itself equally well to the three basic paradigms in sociology. Labeling theory is not necessarily a part or sub-theory of functionalism, conflict theory, or symbolic interaction, but converges with each on particular points. Since the purpose of this study is to ascertain respondents' meanings in relation to their decisions to drop out of AA, the paradigm of symbolic interactionism has been chosen. Labeling theory converges with this perspective in many areas: the assumption of constructed reality, the necessity of understanding the respondent's reality, process rather than causality, non-determinism, humans as actors, and the nature and origin of self-definitions (Schur 1971).

In order to explore the meanings and realities of the respondents, ethnographic interviewing techniques have been applied. According to Spradley (1979), the importance of language cannot be underestimated. Since every ethnographic study is a translation, the goal is to translate as

closely as possible what the realities of the respondents are through the medium of language.

Unlike surveys or questionnaires, the ethnographic interview is not so formally organized. Spradley (1979) states that the interview shares facets of a friendly conversation in that both are flexible and are expressions of interest. Unlike a friendly conversation, the researcher engages in the larger amount of listening of the two conversants, asks clarifying questions, and encourages expansion of topics.

In trying to decipher meanings, the research interviewer utilizes relational processes. That is, the interviewer attempts to discover the "system of symbols that constitute a culture" (Spradley 1979, p. 97). In this attempt, meanings between the interviewer and the respondent are negotiated in an effort to arrive at a dual understanding: that the respondent "understands" the meaning of the interviewer's questions, and that the interviewer in turn "understands" the responses.

Open-ended interviews were conducted with ten women. A snowball sample was attempted, but as the women tended to be isolated from other ex-AA attendees once they had left the program, an alternate method of locating respondents was devised. Advertisements were placed in local newspapers of two states and on the campus of the university wherein this research took place. After the respondents contacted the researcher, interviews of approximately two

hours took place with each respondent in a setting of her choosing. Normally, this setting was the respondent's own home. With the respondents' permission, a tape recorder was utilized in order to facilitate the flow of conversation. The research questions (see appendix) were used merely as a guide to the conversation, rather than in a question-and-answer format.

The goal of the research was to interview respondents until responses began to be repetitious, but this was not possible due to the unanticipated difficulty in finding respondents. Over a period of one-and-one-half years, the total number of responses to the advertisements only totalled fifteen. Five of those fifteen did not keep either their first or second appointments. More interviewees were found in a shorter span of time in one of the states as compared with the other, but time requirements and distance precluded obtaining more interviews from that state.

The ten women interviewed ranged from the middle twenties to the middle fifties in age, with a median age of 33.5. Most were employed or attending college. The majority were single (including "divorced") at the time of the interviews, and six of the respondents had raised or were raising children. Some of the women were or had been members of other 12-step programs (for example, Al-Anon, Overeaters Anonymous, or Narcotics Anonymous).

Length of attendance in AA varied widely, from only a few meetings to five years. No "typical" length of atten-

dance was apparent. Both inpatient and outpatient meetings were attended; inpatient meetings were those meetings required as part of an inpatient treatment program.

The experience of other- and self-labeling as an alcoholic will be explored in the following chapters. An emphasis will be placed on this process at three different time periods: before AA, during AA, and after AA. Initial discussion in Chapter IV will center on the respondents' early awareness of alcohol and its meanings, and will include experiences in the respondent's family of origin. The women's drinking careers will be examined in Chapter V, with a focus on the motives and feelings attached to the drinking behavior. Chapter VI will follow with the women's experiences in and reactions to AA. The definitions of alcoholism as they apply to the women's lives at the present time will comprise Chapter VII. Chapter VIII will summarize the research findings.

CHAPTER IV

EARLY AWARENESS OF ALCOHOL AND ITS MEANINGS

Past events, and the memories and feelings associated with those past events, are always interpreted in the present (Mead 1932). Despite this observation, no other practical method of finding out about past events exists other than interviewing in the present. However, no research is possible without believing that respondents honestly and accurately represent and communicate past and present events, memories, and feelings. This chapter begins the presentation of the interview data, utilizing the observations listed above as dual guideposts.

The respondents varied widely regarding their early awareness of alcohol and its meanings. For two, heavy alcohol consumption by a parent resulted in very noticeable family problems. One of these two respondents could not recall a time growing up when her father did not drink. At first, she associated his drinking with "fun," because she was allowed to accompany him to bars where she could drink pop and play cards. Problems arose, however, when her father began to request that she lie to her mother about where they had been. In addition, her father's drinking

meant that she (as well as her brothers and sisters) had to cover any work that he was unable to perform because of his inebriated state. She eventually grew to hate her father and the drinking that caused the problems. When he would not stop drinking despite the problems, she assumed:

> it was because he didn't want to, and I couldn't understand why he didn't want to because it was causing so many problems.

Her hatred of her father ceased after he almost died when she was thirteen.

The second respondent reporting awareness of noticeable problems with alcohol while growing up nevertheless did not associate those problems with alcoholism. While she described her father as drinking "to excess" and as becoming violent when he drank, his volatile temper was pinpointed as the cause of the problems. She did not think about alcoholism much while growing up, but knew that she did not want to imitate her father's drinking pattern.

One woman's father was described as alcoholic, although she did not make this discovery until she first met him during her teenage years. At this meeting, he told her that, because of his drinking, he thought his family would be better off without him. For this reason, he had left his family many years before.

Two respondents were not certain that their fathers were alcoholic, because these parents were able to function adequately despite heavy drinking. The first of these two

respondents termed her father a "borderline" alcoholic, which she described as

> someone who is really an alcoholic, but is still able to function at acceptable levels, and so nothing ever has to be done about it.

She was not sure whether his drinking contributed to the problems the family experienced. He drank when he was depressed, and on some occasions (beginning when she was seven) kept her up at night talking to her about his problems.

The second of these two respondents was unaware that her father drank very much until she was a teenager. By this time, she was living with him after her parents separated, and his frequent absences were more noticeable. Alcohol had always been present at home while she was growing up, and she and her siblings were allowed alcohol on many occasions. Drinking seemed a normal part of life and growing up, although her father's absences from home when she was a teenager elicited feelings of hurt and rejection.

Two respondents indicated that, while they were aware of alcoholism or problem drinking in their extended families, no problems were ever experienced in their immediate families. Their parents either did not drink, or did not allow alcohol in the home. Neither of these women reported much awareness of alcoholism while growing up.

Similarly, two other women who reported no alcohol problems in either immediate or extended families grew up

with little awareness of alcohol. One of these two interviewees stated that she was not even aware that people drank until she was eleven or twelve, since she was not raised around it at all.

The last respondent reported having been aware of alcohol consumption in her family, but because no stigma or negative feelings were associated with it, she viewed drinking as a normal occurrence. However, she had since classified her mother as "probably alcoholic."

The issue of awareness of alcohol while growing up is important to a labeling perspective because connections between labeling oneself as an alcoholic and one's early experiences with it can then be made. Quantitative approaches predict that early experience with alcoholism in one's family of origin correlate with respondents' own alcohol abuse. Conversely, the qualitative approach of this research shows a variety of early experiences with alcohol, despite the similar outcome of problems with alcohol. For example, some of the respondents have been shown to have come from "non-alcoholic" families. Another finding is that women who grew up with negative feelings about alcohol still wound up drinking heavily.

Another finding in the alcoholism literature involves women's heightened feelings of poor self-esteem, depression, isolation, and anxiety. Since these feelings are part of one's self-concept, and self-concepts are involved in the decision-making process of self-labeling,

the second half of this chapter will look at the women's early feelings about themselves.

Six of the women reported difficulties growing up, although some of the terms used to describe these times had been applied more recently. Various descriptions of family life included "crazy," "not easy," "very dysfunctional," and "tense." One respondent felt very "different" as a child because of her absent father. Despite being a very good role model, her mother paid such excessive attention to the respondent when she was younger that she felt relieved when her mother remarried and focused more on her stepchildren. Religion produced some negative feelings for this woman, originating from supposedly-religious people's responses to her mother's divorce.

Another interviewee's difficulties revolved around poverty and a very tense relationship with her mother. One woman reported feeling something was wrong with her as a result of being taken to a psychologist when she was young. She also reported not enjoying social relationships to any great degree when she was young. She had been very involved with a church group as a teenager, but a rebellious incident resulted in ejection from the group and prompted strong feelings of rejection.

The woman describing her family as "very dysfunctional" remembered their isolation and the responsibility that she was given for her brother by her father because her

mother was unable to take care of either of them. However, she felt that the responsibility was her duty, since her mother also relied on her. She desired a normal family life, and felt, at that time, that accepting the responsibility for the family was the way to obtain it. But despite accepting the responsiblity, she had not felt that she was a very successful or "good" parent.

The respondent whose father's drinking caused severe family problems described herself as never very close to her mother, who disciplined the children when she was having difficulty with her husband. This respondent reported being close to her brothers and sisters, however, because they "had to survive."

The last respondent who reported difficulties in growing up remembered embarrassment over her parents' separation when she was in sixth grade, since separation of spouses was out of the ordinary in the small town where she grew up. She was very shy as a child, although she did not really feel that her family or she was abnormal until high school. Increasing visits to other classmates' families and comparisons of them with her own prompted feelings of being very different from other people.

The remaining four women described their feelings about growing up as "normal." One described her childhood as having been strongly influenced by women, and she described it as "kind of a sunny, quiet time." Her major difficulties while growing up centered on her attempts to

find meaning and acceptance in various group settings. Another, while thinking her home life as normal for a time, nevertheless recalled experiencing much depression. Her perception of home life as normal changed to "a little less than normal" when her mother re-entered school and abdicated some of her responsibilities at home. Tension arose between she and her father when she began working for him. At this time, she drank with him after work, but such occasions elicited the feeling that drinking with her was the only activity he was interested in sharing with her anymore. The final respondent's report of her childhood experiences revolved mainly around her resolution to never repeat her father's drinking patterns.

The tendency of many therapeutic approaches is to explore early relationships in an attempt to discover how certain behavioral patterns get "set up." While a symbolic interactionist-informed labeling theory approach focuses on present circumstances surrounding the choices people make, it nevertheless recognizes that choices such as emotions may become habitual and consequently easier to choose in both similar and non-similar situations. Exploring these women's early feelings, relationships, and awareness of problem drinking is informative in showing that the women may have grown to think of themselves in relatively habitual ways.

CHAPTER V

DRINKING CAREERS AND THE PROCESS OF LABELING

Early Experiences With Alcohol

An analysis of the process of labeling oneself an alcoholic necessitates an examination of one's drinking career, since the context of drinking is obviously the locus of that labeling. This chapter will focus on the drinking careers of the ten interviewees. Special attention will be paid to the women's self-concepts, since these attitudes seem to play a crucial role in the respondents' decisions pertaining to self-labeling and seeking help for their perceived drinking problems. Acceptance of a label is a solitary decision, and in some of the cases examined here, the earliest suspicions of a drinking problem were internal. However, labeling can also be influenced by external factors, and cases supporting this observation are also evidenced in the data.

Two-thirds of the women initially sampled alcohol during adolescence. Two of the respondents did not begin drinking until or after the age of eighteen, and two other women first tasted alcohol during childhood. While one of these latter two women recalled that she did not like the

taste of the beer she was allowed to drink, the second enjoyed her first experiences very much. She was allowed access to any kind of alcohol on many celebratory occasions. She associated holidays and reunions with opportunities to drink, and looked forward to them.

Other women also associated their early drinking with pleasant times, one stating that "those [early times] are some of the fondest memories I have." Another remarked that, despite becoming ill the first time she drank, she liked it anyway, because she "could talk" to people and "didn't feel dumb." One woman marvelled at how "unshy" it made her feel, which was a recurrent observation among the women. Another respondent stated, "I thought it was the greatest thing in the world. I didn't understand why people didn't do more of it!" Other reasons associated with good initial experiences with alcohol were the enjoyable times shared with others who were drinking, and the thrill of doing something illegal and getting away with it.

A few of the women purposely chose alcohol as a means of dealing with problems they were experiencing. One woman stated that, while she preferred to drink alone, she usually drank with others as a form of rebellion against a difficult home life. Another said she also used alcohol as a way to escape from problems at home and to alleviate the discomfort she always felt at the parties to which she

would escape; she stated, "Drinking was a way for me to relax and to relate."

The most specific utilization of drinking as a means of alleviating problems came from a respondent who began drinking when she was twelve. Her father drank when he was depressed and would keep her up nights talking to her. She stated:

> I'd been depressed for five years [prior to age twelve], off and on. I decided I would try drinking like my dad did and see if that helped any.

Her first episode made her feel "more in control, more like an adult, less helpless." However, she was not sure that it made her feel less depressed, despite the added control.

Later Experiences

Alcohol consumption gradually increased in frequency as the women matured, creating special problems or heightening already-existing ones. One respondent described her drinking to be associated with control:

> I had to be in control, and I always was. Any given situation, I was in control. I was the leader. I was everybody's neighborhood shrink. I always had a dollar for gas or an extra cup of coffee or an extra cup of sugar. I was the one everybody came to.

Drinking seemed to make her happy, but she had periods when she would stop drinking because she felt that her life was "going down the toilet," since it sometimes interfered with her ability to save money.

Another respondent reported using drugs more than

alcohol, because she felt more in control with them. With alcohol, she felt less safe because she lost awareness of drinking. After a traumatic experience associated with the only blackout she ever experienced, she decided, "I never wanted to black out again because I always was afraid I'd go past my limit." With alcohol, she explained, "I felt like I didn't have any self-control at all," and that "I might say or do anything."

One woman outlined the difficulties in her adult life that corresponded with bouts of heavy drinking. She preferred drinking alone, although she usually drank with others. She returned to solitary drinking when her second husband, who had previously drank heavily with her, quit drinking. She stated that she hid her drinking during the day, and "couldn't wait" until evening when she could drink more openly. She did not associate other problems she was facing with drinking, but was aware that her life was not going the way she wanted it to.

Another respondent thought her drinking quite normal for a long time, since she did not feel compelled to drink. She had been raised in a household and environment where drinking was present and non-stigmatized. Everyone she knew drank, and drinking was the primary choice of entertainment for her and her friends. Early in her drinking career, she was able to drink a large amount of alcohol without feeling any ill effects, but these effects began to grow as her drinking progressed.

She married while experiencing long-term difficulties with her mother and a boyfriend. She stated,

> I was exhausted from fighting all these situations, and he was a very take-charge kind of guy, and someone I could lean on.

However, she liked that for "about three months;" then the dynamics of her marriage and the small-town life she was leading became claustrophobic. She recognized that she drank more than her husband did, but that awareness did not prevent her from drinking and often "embarrassing" herself in front of family and friends.

As with the previous interviewee, another respondent spent the first twenty-five years of her life in an environment wherein drinking seemed normal. It was associated with Fridays, weekends, holidays, "bad" days, celebrations, athletic events, weddings, and many other occasions. She had been allowed to drink as a child, and did not notice the extent of her drinking until her senior year in college, when it occasionally interfered with her studies. She associated her heavy drinking then with "wild, fun times," though the increasing depression that she was trying to alleviate by drinking was exacerbated once she exceeded a certain limit.

Early in adulthood, drinking was "never a big deal" to one respondent, since she was able to stop when she so desired. In addition, she was able to consume a large quantity of alcohol with few ill effects. However, upon re-entering school, her drinking increased, and a

difficult and confusing relationship created a great amount of stress. She remarked:

> This was when I [started] drinking for other reasons than just having fun. I was drinking [in order] not to have to deal with all those feelings, because I was so mixed up, so messed up, so strung out, that I was having a hell of a time trying to keep my head above water.

Later, she was fired from a job for allegedly drinking during working hours, and recounted:

> I was worthless at that point, 'cos I had never had anything like that happen to me. I didn't think it was fair, but yet I didn't know how to fight it. I didn't feel like I could fight it back. And so my answer to that was just sticking my head in the bottle.

At this point, everything "kicked in" with regard to her drinking: blackouts, physical withdrawal, and confusion about time. Her drinking then began to revolve around periods of "drying out," followed by the resumption of heavy drinking.

Another respondent stated that her drinking was fairly stable for a number of years, until a doctor prescribed tranquilizers to help her deal with a personal difficulty. Her drinking increased suddenly at that point.

A respondent describing herself as a "gulper" recounted that she could outdrink most of the people with whom she partied. After her divorce, she curtailed her drinking to a degree. Soon, however, her drinking increased again, and she began experiencing regular blackouts.

One woman began drinking regularly with her father

after work when she obtained a job from him at fourteen. By sixteen, she was drinking every weekend, and sometimes every day if liquor were available. She recounted that she drank out of desperation and in order to comfort herself.

Realization of Problems With Alcohol

Eventually, the women decided that their drinking caused problems. This section will explore the experiences and self-concepts associated with their growing realizations.

An extremely traumatic event following a night of heavy drinking led one interviewee to decide that she would never drink again. Although she did not actually stop completely, her consumption decreased dramatically. Upon joining a Twelve-Step program (for help with a non-alcoholic problem), she noticed that its members did not drink or use drugs at all, and she began to feel that "if you were really on the spiritual path, you didn't ever use anything." At this time, she felt "insecure" and "co-dependent" (the latter was defined as being very influenced by how other people felt, and needing them to feel happy in order for her to feel happy). She elaborated:

> I was always placating everybody. I would walk a mile to avoid problems. I was discontented with life in general terms. I felt out of place and sort of unsure about the meaning of life and where I was going and what my role should be. [I was] directionless, like, I was busy letting go of my family of origin, busy letting go of the religion I'd grown up in. So it was, like, I'd let go of all these things,

> and I think rightly so, but then I didn't have anything to replace them.

She recounted her drinking history to her sponsor, who informed her that she was an alcoholic. No one had ever said anything to her before about her drinking, and she felt that her sponsor's observations were "logical." Consequently, she began attending AA, although she stated, "I really dragged my feet" about it.

Three factors contributed to one woman's decision to attend AA. The first factor was a workshop on co-dependency which she had attended and felt "blown away" by. Prior to the workshop, she had been dating an experienced drinker, and her drinking had increased in quantity. However, the relationship had soured, and she soon discovered that she was no longer drinking for fun. A night job, which eliminated frequent partying, was the third factor in her decision. She described herself at this time as lost, undefined, confused, lonely, insecure about being accepted, and not feeling like she fit anywhere. Some of those feelings emerged from her participation in the previously-mentioned workshop, while the loss of the relationship with the experienced drinker, plus another loss of a close friendship at approximately the same time, were also influential. The final catalysts were insinuations from others, who continually asked her if she were in an alcoholism program.

One interviewee briefly attended AA at seventeen, upon the advice of her doctor. She did not attend again

until she had been in treatment a number of times for her drinking. During her first time in treatment, she remembered thinking that she may be alcoholic, but she stated that she "kept pushing that idea down." Despite more than one hospitalization for drinking-related problems, only her doctor (when she was seventeen) suggested that she may have a problem with alcohol. However, she stated that her tolerance level was so high that most people were not aware of how much she drank.

By the third time in treatment, her life was chaotic, and she admitted that what was happening to her would not be occurring if she were not drinking. She called AA, who sent representatives to accompany her to treatment. She described herself at this time as "drained of goodness," desperate, hopeless, "very, very sick," unable to get in touch with herself, and having trouble distinguishing between dreams and reality. She thought she was "going crazy," and felt totally hopeless. She felt she needed a miracle because she was "pretty close to the bottom."

A fourth respondent had been in some trouble in her teenage years as a result of using alcohol and drugs, and consequently decided at that time to be more careful so that she did not get into additional trouble. Her drinking history involved multiple occasions of heavy drinking followed by abstinence. She drank heavily with her husband until he quit, at which time he told her that he thought her drinking would ruin their marriage. She felt that she

wanted to quit drinking then, and, though she thought that religion would help her the most, joined AA. She stated that she could not stand to be around herself, as she found herself to be disgusting. She thought that no one could respect someone who was drunk all the time. Her many role demands caused her much stress and anxiety, and she felt pulled between wanting to fulfill the roles and wanting to drink.

Another woman began thinking about AA during her marriage, when she would take "alcoholic quizzes" and "flunk" them. However, since she did not think of herself as an alcoholic, she did not believe the results. Her version of an alcoholic was a person who drank every day and was compelled to do so, and she did not fit this description. Eventually, she sought the opinion of a friend, who pointed out that her personality sometimes changed dramatically when she was drinking. Since no other person had ever been as frank with her, this statement had great impact. Conversely, other friends thought that there was nothing wrong with her drinking, as it was associated with problems she was experiencing at the time.

An alcoholism counsellor's declaration that her drinking was not normal caused concern, but no action was taken. She continued drinking for a few years following the discussion with the counsellor, and she noted, "Every time I drank I got drunk." Finally, following two incidents in which she purposely tried, but could not

control her drinking, she stopped drinking completely. She asked the man she was seeing at the time if he thought she was an alcoholic, and he answered that he thought she may have a problem, and suggested she try AA. When she joined, she was feeling proud of herself because of some changes that she had made in her life. Exploring her problems with alcohol was the sole reason for attending the meetings.

The sixth respondent, like the third, was treated for alcoholism a number of times. The first time was the result of seeking therapeutic help for a confusing and anxiety-provoking realtionship. She had become suicidal, and went for help at the advice of a roommate. When she entered the facility, she was asked about her drinking, and was subsequently referred to a person who told her that she needed treatment for it. Because of this unexpected advice, she stated:

> I was really mixed up right away, because to me, that wasn't what the problem was. Yes, I was drinking, but that was not the initial problem.

However, since she was desperate for help concerning the relationship and had no one else to talk to, she went to treatment for alcoholism. The treatment program incorporated AA into its structure.

More alcoholism treatments and stays in detoxification units followed, along with the recurrent pattern of abstinence and resumed drinking. At one point in her drinking career, she began experiencing withdrawals and needed a drink in the middle of the night in order to stop

shaking. Following the fourth treatment, she said,

> Something just clicked. I'd been fighting this for years, and the answer was to give up. The only way I could win was to give it up, to give up this fight.

Unfortunately, she felt that she "lost something" following a slippage after having been sober for two years.

Another respondent considered herself a social drinker until her father died, after which her drinking frequency increased dramatically. She also began taking pills at this time, and the combination landed her in the hospital after a month. During her stay, she was diagnosed as an alcoholic and drug addict. She remarked that she did not accept the diagnosis, since her version of an alcoholic was a "falling-down drunk" or "bum" who lived in alleys. She said that she initially "exploded" with anger at being labeled, but then realized that sociability was no longer the reason why she drank; she drank simply in order to get drunk.

She stated, "Nobody really pushed me into treatment," although she had felt some pressure to change from her family and place of employment. When she finally committed herself into treatment, she felt belligerent, combative, insecure, very paranoid, and depressed. The final deciding factor was her realization that

> anybody that drinks or does drugs of any kind can convince themselves that they're only hurting themselves, but if they're going to be realistic about it, they're hurting a lot of other people, [too].

Part of the treatment requirement was AA attendance, which she continued after leaving the treatment facility.

One woman stated that, except for the first time she drank, her drinking "from then on probably was never normal." She described herself as a "workaholic" at the time of her divorce, but two years later her drinking had increased to where she was experiencing regular blackouts. She attempted to control her drinking by counting and switching drinks, and by going to different bars. Her loss of control over her drinking prompted feelings of anger, depression, and confusion. Eventually, one of her friends confronted her about her drinking; her response was a deep depression. She went to counselling, and stated that, despite being curious as to whether or not she had a drinking problem, her major reason was to prove that she was <u>not</u> alcoholic. After she terminated therapy, she concluded that she was a "problem drinker."

After a period of time, she joined an outpatient support group because of other problems that she was experiencing. She had low self-esteem and was very depressed, although she attempted to hide it. She felt that she had "a long way to go" to make a life for herself, and that what she wanted from life was intangible. She felt different from everyone else. A group member's description of a spouse as a "periodic alcoholic" seemed to be an appropriate description of herself, and she used the term during group meetings. As a consequence, her

outpatient evaluation counsellor suggested that she sign up for an inpatient alcoholism treatment program.

When the ninth respondent sought therapy for problems she was experiencing, she felt herself to be very intelligent and talented, but did not like much else about herself. Drinking was the only means available to comfort herself. She stated that she had first thought about her drinking at seventeen, when friends noted it. She stated,

> They wouldn't say anything bad, they just gave me so much attention that I thought it must be abnormal, to have that much attention called to it.

Her father's heavy drinking also influenced her awareness of her own.

She decided to stop drinking for a period of time after her therapist pointed out her drinking problem to her:

> She [the therapist] was the one that decided that I had a problem with alcohol. I mean, she pointed it out to me. I guess I had to decide myself.

She described her reaction to the therapist's observation:

> I kind of agreed with her, just because I had seen my dad for so long, and I had decided that my <u>dad</u> had a problem with alcohol. So I could talk about my dad and all his alcohol problems, and she would point out the similarities between him and me.

However, she began drinking again in a few months because she did not feel better upon cessation. She said,

> I thought that if I stopped drinking, everything would be great, and I would be this great student again and my life would be perfect.

Instead, her feelings grew worse, and she became suicidal. Her therapist suggested that she leave school and obtain treatment for her drinking, since she did not know how to live without alcohol. Consequently, she attended three Alcoholics Anonymous meetings and then signed herself into a treatment facility for alcoholism.

The last respondent recalled that therapy was the first setting in which her drinking was called to her attention. To her surprise, she was given AA pamphlets to read, but as the subject was never explored further in therapy, she eventually stored the pamphlets away without much thought. Her drinking became a serious issue five years later when, for the first time, she lived with non-drinkers. Her drinking seemed abnormal in comparison, and tensions rose with regard to it. She remembered her resentment and defensiveness during visits from a friend of one of her roommates, because the friend was an AA member:

> I felt like I had to hide my beer whenever she was around, and then I was angry at being ashamed. I couldn't figure out why this person affected me so much, but I really <u>did</u> look like an alcoholic compared to my roommates and compared to her.

She returned to therapy for her recurrent and severe depression. She "loathed" herself, and felt very angry, out of control, and fatalistic about the future. Her therapist had gently told her that, while she usually did not accept clients with drinking behaviors such as the respondent's, an exception would be made. Due to the trust built from this early acceptance, the respondent quit

drinking after six weeks into therapy. She stated, "At the time, I sort of tricked myself into quitting," because she wanted to impress someone she was attracted to. However, she stayed sober to prove to herself and to others that she could do it. She began going to AA soon after she quit drinking.

Perceptions of problems in the respondent's lives have been shown to take a variety of forms. In some cases, a single dramatic event spurred action directed at making changes, while in other cases, awareness was much more gradual. Major influences on the women's concern with their drinking were both internal and external. Most frequently, information from therapists/counsellors or those close to the respondents were significant. In addition, not every woman decided that alcohol was the major problem needing to be changed. Depression, introversion, lack of control, low self-esteem, anger, and feelings of isolation played parts in their decision to seek help. The next chapter explores one of the means by which the ten respondents sought to effect a change in their lives: Alcoholics Anonymous.

CHAPTER VI

THE AA EXPERIENCE

Each respondent's experiences and feelings with regard to Alcoholics Anonymous will be explored in this chapter, with the attention given to how these experiences and feelings impact on the process of labeling. AA was chosen for three reasons: the program is the one most familiar to the public, the majority of people with alcohol problems are referred to it, and AA boasts the largest success rate for alcoholism rehabilitation. Focusing on women who no longer attend AA necessarily results in obtaining assessments of the program's efficacy.

The first respondent entered AA from another Twelve Step program (others examples of Twelve Step programs include Al-Anon, Overeaters Anonymous, and Narcotics Anonymous). Her sponsor in the first program was described as "pretty rigid," and it was she who suggested that the respondent attend AA in addition to the program she was already in. Not joining AA would have resulted in accusations of "denial" and a "tongue-lashing." Yet the respondent trusted her sponsor, because this woman's own success led the respondent to believe that the sponsor must know what she was doing. Furthermore, the sponsor was

"hard on herself," so the respondent stated, "I tried to please her before she could be displeased with me."

Unfortunately, this interviewee's feelings about herself and others changed because of this sponsor. She stated:

> [I had] been finding more acceptance and peace of myself and other people; when I got her as my sponsor, I found myself judging people all the time.

For instance, she constantly monitered AA members' drinking habits for signs of alcoholism; in her words, she "started to be the alcohol police for the world." Upon joining a third Twelve Step program, this type of categorization intensified. Finally, she dropped her sponsor, which resulted in what she called the "rubber-band theory:" after being stretched too far one way, "something snaps, and you swing all the way back the other way."

She first joined a well-known AA group, where "the yuppie types go," although there were a large number of group meetings she could have attended. She described the unease she had with the AA identification process, wherein members introduce themselves with the statement, "Hi, I'm _____, and I'm an alcoholic." She stated, "I always felt like I was lying," since she believed the focus of her problem to be something other than alcohol. She recalled:

> A little voice would say "liar!" or "they're going to catch you, this is a closed meeting, you're not supposed to be here!" It was really strange.

One of AA's criteria for being alcoholic was "if you ever used it to make yourself feel better." In addition, alcoholism resulted if drinking ever caused problems in one's life. While she felt herself to fit into these definitions, she also thought that everyone around her that drank seemed to be included:

> I just started feeling like everybody had problems with [many different things], but weren't 'fessing up to it. I started being hypervigilant with everybody's problems...and my own. I just judged myself mercilessly.

Initially, she thought that AA had the answers, but as she "matured" and "grew as a person," "the more I knew that wasn't true. Nobody had it figured out." The Twelve Steps were the closest to figuring "it" out, but "who could say how you were to do those Twelve Steps?"

She remarked that AA "becomes a way that you look at and react to everything in life." In some ways, she saw nothing wrong with the AA perspective. She especially approved of ideas such as trying to get the most out of each day, performing daily meditations, letting minor problems "roll off your back," and "being able to tolerate people more, accept[ing] people as they are, [and] accept[ing] yourself." Moreover, she found the Twelve Steps to be basic spiritual principles for anyone's use. The Steps had a certain framework, yet came from all religions. In her assessment of the Steps, she stated that

> self-examination doesn't hurt anybody; being kind to people or making amends for things you've done wrong--that's just good living.

Nevertheless, she found herself caught in some "spiritual dilemmas." When she felt herself to be on the "right track," she was told that it was because she was in God's grace. When her program did not seem to be working for her, though, she began to wonder, "Has God withdrawn the grace? If it's something that God gives, then God must take it away, too."

The AA program seemed easy at first: "do this, and this happens." But she later felt that perhaps the members were after a fantasy of what health woud be, and when one person, such as her sponsor, was successful, the members thought that she "must have had the answer" and "must have been doing it right, so we had to do it their way." This "rigidity," which she did not find in the first Twelve Step program that she had entered, resulted in what she called "real punitive types of messages." For example, long-time members would exhibit a "pleasant demeanor" while at the same time communicating a different kind of message to new members: "You're a newcomer; you don't have anything to say here; you just listen." She felt angry with this approach.

She also disliked AA members referring to each other as "drunks." Despite being said in an "endearing" tone, she compared it with messages received in childhood:

> if you grow up all your life and your mom calls you stupid, but she does it with a loving tone of voice, it's still "stupid," she's still calling you stupid, and it has an effect on your self-esteem.

She had initially felt accepting of the program, but later felt "tense" and "paranoid." The meetings in which she felt most comfortable became impossible for her to attend, and she was not satisfied with the only one to which she had access. Feelings were never discussed in these meetings, too many AA cliches were used, and the focus was on an endless recounting of members' drinking careers. Overall, she assessed the program as helpful to some people, but

> eventually, you don't need that anymore. Eventually, there's no reason to go to a meeting every day and call your sponsor to figure out if you want diet coke or water for dinner.

She finally ceased attending AA meetings, and cut back her attendance in her original Twelve Step program.

The second respondent found the group experience in AA similar to her unsuccessful attempts to find meaning in groups while she was growing up. She found the "discipline of going" to meetings helpful during her two or three months of attendance, but had trouble making close friends among the membership.

She had hoped to explore her own spiritual nature in AA, and while its spirituality did not supply a good fit, she felt she could "contort it and distort it and make it work" for her. For example, she found the concept of a Higher Power (that is, believing in something larger than oneself and turning one's alcoholism over to it) acceptable, and thought that admitting one's powerlessness was a "very Christian" view. On the other hand, this inequality

forms "a poor basis for a relationship with a higher power." Believing, as AA does, that God takes over what a person cannot handle results in an unsatisfactory parent/child type of relationship.

This respondent found it difficult to relate to members for whom drinking was the major problem, as she did not share their view. Because alcohol was the focus, meetings tended to center on the first part of recovery, or sobriety, and the members dwelt on character defects that threatened sobriety. She felt a need for a group dealing with "life-enhancing, expandable" processes, rather than a group which always revolved around alcohol. She thought that the recovering alcoholic should be able to eventually say that she was once an alcoholic, in a manner similar to saying, for example, that one had once been married. AA's self-admitted narrow focus did not work well for her. She thought the program was well-thought-out, and contained an agenda that worked well. However, she felt that "you [should be able to] just go on with your life, instead of just hitting more meetings and more meetings."

Feelings about herself remained virtually unchanged throughout her attendance in AA. She had joined the program feeling bewildered, and thinking that something was wrong with her. She underwent surgery, and the recuperation period prevented attending meetings. She did not return to AA upon regaining her health.

One of the women, who had gone to AA briefly at the

age of seventeen, called the local chapter shortly before her third stay in an alcoholism treatment facility. The members who responded to her call were very helpful at that time, and she remembered receiving a sense of camaraderie from them. She rejoined AA after exiting the facility, but her initial positive assessment of the program changed when her group of "street people," to whom she could easily relate, became invaded by "rich bitches," who mainly wanted to show off their material goods and talk about how much they had spent on drinks and drugs. Because of this development, she stated,

> I didn't find a fellowship, I didn't find a camaraderie; I found a cult. I found a group of people who tried to outdo each other with stories, jewelry, furs, [and] clothes.

She felt "completely pushed out. Nobody cared [about me], because I didn't hold a white-collar job." She also felt pushed out by members who were also drug addicts, who felt themselves to be "superior" to alcoholics because of the amount of money they had spent on drugs as compared to the alcoholics. This comparison served to imply that alcoholics did not have as serious a problem as did the addicts/alcoholics.

She asserted, "maybe five percent of us were sincere," because the rest of the members were required to attend. This latter group of people just "used" the program by means of role-playing and rule-following. She enjoyed speaking in front of the group, due to the members' respect for her and her knowledge about her topic. But her

speaking caused discomfort among the "phonies," whom she could see through because she had "been one" herself. Those who were uncomfortable sought to discredit her by declaring that she had not yet suffered enough. She had been through many very difficult experiences in her life, and wondered what she had to do to qualify as having suffered enough.

AA's sponsorship program bothered her, especially the view that a person "cannot get sober and stay sober without AA and without a sponsor." Despite receiving a "good" sponsor herself, she had never availed herself of the sponsor's help, because, she stated, "I'm the one who had the problem." She thought that members should not "use their [sponsors'] strength," and that doing so was a "cop-out." She had sponsored people herself, but stated that "if they can't help themselves, I can't do it for them."

"Toughness" was what she needed, but did not receive, in AA. She also wished that she could have had a more therapeutic group atmosphere. While no longer attending AA meetings, she nevertheless occasionally felt a need to go. But the "hassle" of having "to play the damn role" acted as a restraint on attending again. In her view, "AA is a wonderful, wonderful group for those who need it." The program had "kept people alive," and she often recommended it to people. However, despite missing and wanting fellowship of some kind, she did not feel that she needed it, because she could "see through it."

Religious issues were involved in one woman's assessment of AA. She found AA to be hypocritical, since much talk centered on God, yet members did not practice what they preached. AA tolerated anything as far as religion went, and to her, this flexibility seemed too extreme. She had difficulty with others' opinions; for example, she found one person's assertion that she hated God difficult to handle. To her, such statements were "new-age philosophy," into which her own religion did not fit. However, she felt at ease with her sponsor, due to a similarity in religious beliefs.

She began to believe that her church might be a better help to her than AA, an idea she had also contemplated before joining the program. This belief relieved her, since she felt her church to be "more right than AA." To her, AA was "not the real answer," but a "cult." For example, AA believes that alcoholics cannot be cured, but "if God wanted to cure somebody," he could. Whether God would cure an alcoholic was a different matter, but it was nonetheless a possibility. In her opinion, AA needed to "make a Bible," since the Bible contained all of the answers. She related that she was not as close to a church now as she had been before, yet she still strongly believed in her assessment of AA, and that the program will never find the truth the way it is set up now.

She attended meetings for a few years, and at first felt a part of it. A belief emerged that if she followed

the program, she would not drink. She felt that she needed the group, since she was still strongly attracted to alcohol following a stay in an alcoholism treatment unit. She found AA's definitions to be fairly accurate, but eventually wanted to get more out of the program than sobriety. She wanted "decency" from people but found it occasionaly lacking, because they still acted like "drunks" despite their sobriety. Eventually, she dropped out of the program.

One respondent's assessment of AA began with the statement, "I'm so ambivalent about AA." The initial impetus for joining AA was her own questioning of her drinking habits. She wished to discover how to drink without becoming drunk or getting into trouble. Her attendance in AA lasted approximately two years, and she went to meetings two or three times a week. Many of the concepts and ideas in AA were applicable and consequently beneficial to her. For example, at the speakers' meetings that she enjoyed, she discovered that, like herself, others drank at parties due to feelings of discomfort and dissimilarity. In addition, the idea of personal change was agreeable to her. The meetings at which she felt most comfortable were naturally the ones most attended.

AA viewed continued drinking as eventually leading to devastating problems. While not agreeing with AA, this respondent so desired to change her life that she gleaned what use she could of the AA version. Since, as she

stated, "I heard so many absolute statements in AA, some of them contradictory," she necessarily chose between the concepts that helped her and the concepts that did not.

She did not find AA's group meetings either gratifying or enjoyable. Discussions often revolved around "written and unwritten" rules, despite AA's contention that it contained none. Because of these rules, the structure of the meetings impeded meaningful and useful applications to her life. In addition, group discussions required public speaking, which she found very difficult.

Being raised in a non-religious household created difficulties with regard to AA's spiritual nature. At one point in her life, she felt a desire to believe in God, so AA seemed to provide an opportunity to explore this facet of her life. The program was spiritual without denominationalism, which she thought may have been easier for her to accept <u>because</u> of the way she was raised. However, she found some of AA's spiritual answers to be problematic. For example, she had trouble with the idea that "God will never give you more than you can handle." Also, her higher power evolved into a cold and demanding entity, for whom she was never quite good enough. However, she recognized family similarities in her concept of a higher power, and this knowledge was somewhat helpful.

Prior to quitting drinking and joining AA, she had been feeling relatively positive about herself due to some major changes she had already made in her life. Unfortu-

nately, she became more negative and depressed upon attaining sobriety. These feelings continued when she joined AA, and toward the end of her attendance, she felt herself needing to get away from the "negative talk" she found there. For example, when she felt fearful, she was informed that her lack of faith was the cause, and these statements made her feel worse. Such advice "was like dogma," and was instrumental in her decision to discontinue membership. For her, talking one-on-one was more helpful than the group setting of AA. She felt that people who go to AA and have gone for years "need a lot of structure and outside direction," but that that very structure and outside direction was too "constraining" for her.

Sporadic attendance in AA characterized one respondent. Her longest stretch of continued membership was approximately once a week for a few years. Overall, her assessment of AA was positive, although she recognized its limitations with the opinion that "it's the best we've got so far." The structure was of help in her attempt to achieve sobriety; she related that she had unsuccessfully tried to quit drinking on her own.

She had also encountered AA in the treatment programs that she entered. She described why she initially sought help:

> I knew I had to [stop drinking]. I knew it was going to cost me my job. I knew it was going to cost me [my relationship], and I knew I had to stop. I hated it, what it was doing to me....Here I was, someone who hated getting drunk, and getting drunk all the time.

In AA, she found "something to hang on to" and "something to work at." AA's offer of self-betterment and fulfillment intrigued her, and upon meeting AA members for the first time, she thought that they "had something." They were "cool," because they were not drinking, yet seemed to be happy. She "wanted what they had," because she knew that she could no longer function while drinking or control it. This realization presented her with two choices: to feel miserable, or to try to learn what AA people had, and "maybe get some of it" herself. She observed that the Twelve Steps helped others, and was encouraged by the observation. In general, the "spirit" of the people in AA attracted her to the program.

Despite her overall positive assessment of AA, this woman recounted some of the difficulties that she experienced. She explained that she would be "high" immediately after exiting a treatment facility, but then would realize that her problems had not gone away. Consequently, AA attendance was difficult at first, because dealing with her problems while sober was compounded by the lack of new non-drinking friends.

Her biggest criticism of AA concerned its attitudes toward members who "slipped," or drank while attending AA. Sobriety is celebrated in AA with various forms of group recognition, and is always counted from the last time the person drank. A "slip" results in starting the count from after the last slip, regardless of any time accumulated

previously. Her one slip occurred after she had been sober for two years, and she felt it unfair to lose the time that she had accrued. She also thought that her slips had been good learning experiences. For example, she learned lessons "more deeply," and now has greater compassion for people like her, whom she thought comprised the majority.

Her views on total abstainence as rare were further explained by her opinion that AA "has it backwards:" while being a good program for those who are able to stay sober from beginning to end, those who slip do not fit in as well. In her view, those who slip should not lose their accumulated time "as long as they're still trying." Her one slip after two years of sobriety resulted in a change of feelings about the program:

> I had to start all over again, and all the pride I ever had with staying straight (because nobody ever thought I could do it)...was gone. Ever since then, I just lost something as far as the whole AA philosophy [is concerned].

While still of the opinion that the Twelve Steps were beneficial for others, they no longer meant the same to her anymore because of what she felt she lost.

The next respondent's five years of attendance in AA was the longest of all the interviewees. She began attending meetings while in treatment and also while living in a halfway house, and she continued attending approximately once a week after her release from the latter living arrangement. She found it to be "an excellent program," although not suited for some people. While apprehensive of

the meetings initially, the friendliness and support of the people she met there helped to ease the transition, and bolstered her during her difficult first year. Feeling as if she had "hit rock bottom" at that time, she discovered that she could easily relate to others in the program, since everyone in AA had the same problem. She also felt that she could rely on the people in AA.

Her major difficulty in AA involved speaking in front of the group. She recounted an incident in which she was designated a speaker without first being asked, which elicited a strong negative reaction. As she stated, "Sometimes they tried to push me into doing things, and I disliked it. I won't be pushed into doing anything." She also disliked the attitudes of people who were there involuntarily, and who often returned to drinking. She felt that their attendance and input was a waste of their time, as well as a waste of time for members who had voluntarily joined.

AA literature aided her the most. She also benefitted from the speakers' meetings, although the speakers at times went into tedious detail. She found many of AA's definitions, concepts, and ideas acceptable, and credited AA with her positive change in self-concept. She was able to overcome her depression and belligerance, and eventually realized that her drinking hurt others as well as herself.

Two reasons influenced her decision to drop out of the program despite her positive overall assessment. Her

shyness in front of people was problematic, and she feared others' reactions to her as a result of personal revelations to the group by a former friend. These combined to create much tension and anxiety. However, she revealed that she probably would have stopped attending around this time anyway. As she described it, "they've given me the basics, and it's up to me what I do with it from there on." She felt that, without AA, she could not have stayed sober.

The eighth respondent attended AA from two to four times a week for approximately two years. The first year was a "high" for her once she found a group she felt "connected" in, but the second year was more difficult.

During the first year of membership, she felt hopeful and positive about the personal changes she might make in the program. She felt she "needed the structure that AA provided," yet fought that structure at first. As she laughingly explained, "I don't like people telling me what to do!" Eventually, she found a compatible group, and "felt safer there." Overtures of friendship and support were gladly accepted, as she was lonely and "hungry for it." She had been able to make her connection with this group while still in an alcoholism treatment facility, since outpatient AA membership was a requirement of that treatment. She agreed with this policy, "because you can start up your support system right away." Throughout that first year in AA, she felt better able to handle life, although some of the Steps were problematic.

Despite disliking being told what to do, she decided to accept the structure of the program, and she was consequently able to "fit in better." Concerned as to whether or not she had been "playing a game" at that time, she nonetheless felt sincere in her effort to "get that something that I thought other people had," such as serenity and happiness. Over time, frustration emerged out of her apparent inability to achieve her goals. Everyone else appeared to be happy except her, which led her to conclude that she must be doing something wrong. For example, she unexpectedly found the Fifth Step ("Admitted to God, to ourselves, and to another human being the exact nature of our wrongs") to be difficult to practice. Instead of feeling uplifted, as others had described, she felt a stronge urge to drink.

The major turning point in her feelings about the program resulted from discussing her misgivings with her sponsor. In the course of those discussions, she revealed some personal information about herself to her sponsor. Unfortunately, this information was repeated to others, and she stated, "My perception was that I fit into the group differently after that." She explained her feelings further:

> I never felt the closeness of people after that....It really hurt; it really cut deeply. I thought I'd finally found my niche,...and then I didn't feel it anymore. It felt really "surface" after that.

Other problems with the program emerged in her second year. She found AA to be not very accepting of those who had left the group because of a slip or some other reason and who then attempted to come back. She said that "it was a contradiction that certain people couldn't get help." The over-use of the personal inventory, whereby members explored their "character defects," also troubled her. She explained that whenever members experienced problems in their lives, the AA remedy was

> "well, you'd better do a personal inventory," and I just got so tired of listening to people putting themselves down and dragging themselves through the gutter.

She felt that a balance was needed:

> My perception was that they thought it was always your problem, and I don't think it necessarily was, or that it was always beneficial for people to <u>think</u> it was always their problem.

She began to feel better when she did <u>not</u> attend meetings, although she continued going in hopes that her feelings about the program and the way others were treating her would pass. She felt angry about not being able to do anything right in AA, and eventually left the program. Outside of its influence, she began to find out that beliefs she accepted from AA were not always true. Her most important discovery was that alcohol was not the focal point of her life.

One of the women's experiences with AA consisted of two or three meetings and a six-week experience in a treatment facility which incorporated an AA program into

its structure. She was not impressed with the program at the meetings outside of treatment that she attended. The members were not in her age group, and she thought them to be "kind of weird." For instance, she had expected the meetings to function as a support group, but found the people to be solely focused on their attainment of sobriety, as indicated in statements such as "'I quit drinking a year ago, and my life has been hell ever since.'" Her impression of life without alcohol was that people quit drinking,

> and now they're either miserable or Christions. [Those] didn't seem like very good options. But I went anyway, because my therapist thought it would be good for me, and I trusted her.

The six weeks of treatment were more beneficial. The people there were closer to her own age, and she found "some people [who] were serious and normal," like herself. She also discovered this group to be "intelligent," although more experienced than she. Because many of them had been in jail, she contributed little to group sessions. As she explained, "If I told <u>my</u> story, it would be so miniscule" compared to theirs. She felt "in awe" of them, and stated:

> I was really impressed that they were there [because they seemed intelligent]. But I guess I was a little <u>too</u> impressed: I wouldn't say anything.

The program at the treatment center ran like a "small community." Residents were expected to "work" at a task every day, and free time was kept to a minimum. The

residents progressed through different phases of the program, which included the "fake work," group therapy, AA meetings, and a demerit system. The structure was beneficial for her, because she was able to gain practice in functioning without alcohol, and learned how to get along with people in general and in particular and how to be more assertive. Though believing her major problem to be depression, rather than drinking, the program nevertheless showed her how to stay busy without "competing" with herself.

The AA meetings she attended there usually revolved around one of four themes regarding AA's philosophy. They were less helpful than the treatment program as a whole because they seemed repetitious and without any "great answer." A major hindrance of the AA portion of the program was its "sensationalism." As she explained,

> If you haven't been to jail and if you haven't tried to kill yourself twelve times, only once or only five times, [then] you're not really an alcoholic. Or if you haven't run over people, you're not really an alcoholic.

In the one-on-one setting of this interview, she hoped to avoid having her story and viewpoint "diminished" by comparison with others' "great stories."

She was asked to leave the treatment program after six weeks because of a rule violation. Since the AA portion of the treatment had not been particularly helpful, she did not attend AA after she left the facility.

The final respondent had the least amount of experi-

ence (three meetings), but the most pronounced reaction to AA. The spiritual nature of the program was anathema to her, because she had spent many years throwing off the "shackles" of the religion she was raised with, and the Twelve Steps were too similar to "commandments." As she recounted,

> My religious upbringing did not foster very high self-esteem in me, and so I rejected it when I was in my twenties. When I first read the Twelve Steps and saw all the "God this" and "God that," my reaction was quite overwhelming: I felt like all the important changes I had made were about to go right out the window.

Much of her reaction was due to the unexpectedness of finding religion in the program. AA had been suggested by her therapist, and its religious nature left her feeling angry and "duped." Especially vexing was AA's concept of a "higher power," wherein control over one's drinking is imparted to an entity other than oneself. She felt that lack of control over her own life was one of her major problems, and so needed to learn how to use it rather than give it up.

Other ideas created provocation. In one of the meetings that she attended, the group advocated avoidance of anger as a means of maintaining sobriety. She felt, conversely, that "getting in touch" with her own anger was more healthy than denial or avoidance. In addition, she reacted strongly to the "absoluteness" and "self-righteousness" she found in AA. For example, she had been told that she would never succeed in her sobriety without AA.

Since she had only quit drinking a short time prior to hearing this assertion, she felt that AA took "unfair advantage over people who are in a very vulnerable spot."

She was impressed by the camaraderie of the meetings, but this pleasant discovery was not enough to tempt her into continued attendance. She credited private therapy and the support of friends as the major sources of help in facing the world without alcohol.

The experiences of the ten respondents in AA run the gamut from intense dislike to positive affirmation. Given the nature of this research, it was not unexpected that AA was deemed less-than-perfect even by its supporters. The respondents conscientiously attempted to present an honest view of their experiences and feelings, and quite naturally focused on the factors that were the most influential in relation to their feelings about themselves vis-a-vis alcoholism. The summary and conclusions of this research report will explore patterns evolving from this data.

CHAPTER VII

THE PERSPECTIVE OF THE PRESENT

The process of labeling oneself (or not labeling oneself) an alcoholic reaches its natural conclusion when explored from the perspective of the present. Whether or not the influence of AA contributed to changes in self-concept and views on alcoholism will be explored in this chapter. The respondents are divided into three groups in this section: those who presently consume alcohol, those whose experience with sobriety remains relatively problematic, and those who both abstain from alcohol and have settled on definitions and self-concepts that allow them some degree of comfort.

Two women reported that they occasionally drink alcoholic beverages. One had already decreased her drinking prior to joining AA because of a traumatic experience. Her drinking increased again for a period of time, but then decreased to its present state. She abstained completely during her membership in AA. She often does not drink at all, nor misses drinking during those times. Her drinking was "no big deal" to her now, although she expressed a need to be "careful," as she thought herself to be "biologically predisposed to

alcoholism." Despite this predisposition, she stated, "I know what alcoholism is today, and I am not one. I am not an alcoholic." She opted for a more situational definition:

> There isn't a psychiatric diagnosis called alcoholic or alcoholism. It's simply alcohol abuse, or alcohol dependence. AA calls people alcoholics, or they talk about the disease of alcoholism.

Her more flexible definition recognized that people may use alcohol to deal with some situations in their lives, but "that doesn't necessarily mean they're alcoholic." She viewed her past alcohol experience as a normal teenage "acting out," influenced by many situational factors which

> just came to a head in those years. Today, I don't need that. I don't need to use like I used back then. And today, if I have a drink, I don't beat myself for it.

At the end of her membership in AA, she felt tense, paranoid, and judgmental. She described herself now as more accepting and tolerant, curious, calm, and independent.

The second respondent in this group also reported a lack of compulsion to drink now, unlike her feelings when she was younger. She had never identified alcohol as her major problem, although she recognized that she used drinking as a means of self-medication for her problems. Her present definition of alcoholism was unformed, and she was not yet sure whether she belonged in the category. She described the major focal point in her present life: "I'm learning how to be in control of myself, or how to live with it if I'm not." Her actions were now properly

understood to be decisions, and she had learned to accept those decisions and the way they affected her feelings.

The second group of women reported on-going discomfort and dissatisfaction with their present state. One of the respondents in this category described her continuing effort to control the temptation to drink. She had a "hate/love" relationship with alcohol, and "it's always there waiting," but she tried not to dwell on those feelings, since such preoccupation worsened them. The term "alcoholic" was aversive to her, although she did not know how she felt about the concept beyond that aversion to the label.

She described herself as low in self-esteem, intolerant, and impatient. A "sensitivity" that she felt a year ago had been replaced; she now thought of herself as "hard." She did not think herself to be very intelligent, and felt that others misunderstood her. Other self-descriptive words included curtness, irritability, and shyness. Religion had always been of major importance to her, but was less than sustaining at the present time. The apathy that she now felt for religion "scared" her. The many pressures that she had described upon her entry into AA continued to be problematic.

The second woman in this category reported that she knew she did not want to drink again because of where it would lead her. However, due to the experience revolving around her slip after two years of sobriety, she stated,

"If I do [drink again], it's not that big a deal anymore." Accepting the label of alcoholic was difficult because, as she explained, "I had never been able to fall down by myself." That is, entering treatment for her drinking had always been someone else's idea rather than her own. She felt personal choice to be of major importance: "Everything I"ve ever done in my life, it seems I have to learn the hard way." To her, alcoholism was a complex issue, with "as many definitions as there are alcoholics," although she thought that alcoholics probably experience blackouts, personality changes, and lack of control over their drinking.

She knew that she would never revert to constant drinking because she would seek help before she harmed herself. She stated that she presently felt better about herself, and that both treatment and being an alcoholic had taught her much. However, she felt like a failure at times, because of her slips and because of the frustration of feeling that she was now where she should have been at eighteen. Her "problem-solving skills" seemed underdeveloped, due to her family background and her problems with alcohol. She stated:

> I came up against something that was a lot bigger than me, and I came tumbling down, and that was really hard to deal with.

She presently felt cautious about her life, and was attempting to progress slowly. However, feelings of frustration were common, because she was aware that such

caution prevented her from living up to her potential.

The six remaining women are totally abstinent and more satisfied with their present lives. "Satisfaction" did not mean unquestioning acceptance, certainty, or complete happiness, but ranged from mild optimism to a fairly high belief and hope that their lives were now on a more positive course.

One of these women described her life as having gone "downhill" since she took her last drink two years ago. Everything that could have possibly gone wrong had gone wrong, and she listed her losses: her physical health and possessions, her self-respect, self-worth, and her "mind." She had had to face reality without alcohol, "and it's not pretty." She had never known that people were so "nasty" and "hateful," "especially the higher-ups." Despite this extremely negative assessment, she had been able to adjust, because being in possession of her sobriety was the most important consideration. Whenever the temptation to drink again emerged, she stated, "I only have to remember any given day in the last ten years, and that's enough to scare me out of it."

Her own experiences with alcohol's effects, which she described as physical addiction and deleterious health consequences, influenced her definition of alcoholism: "I can't see that it's inherited. I can see that it's a disease, though." However, except for her physical addiction, she was hesitant to label herself an alcoholic,

because she did not think or feel like one, nor believed, as AA asserts, that she needed anyone in order to get sober. She also suggested that a drinker's belief that she cannot function without alcohol will produce alcoholism, and that she does not share this belief. She thought that many people used the label as an excuse, as she did at one time in order to gain pity. As she explained, "There are a lot of doors open for admitted alcoholics that aren't open for us 'common folk.'"

Although she did not believe that happiness was a possibility in her sobriety, she nonetheless was rapidly approaching "peace of mind." To her, sobriety required self-reflection and self-identification. The "outside stuff" was not necessary.

One woman felt better since leaving all the "negative talk" she found in AA. While she occasionally was tempted to drink, "there doesn't seemed to be a good enough reason yet." Her present goal, to "get my life on the track that makes me feel comfortable" and happy, precluded drinking. Definitions of alcoholism that she was acquainted with left her uncertain about the application of the label to herself.

She stated that happiness with herself was a precondition of further development. In some ways, she felt that she <u>was</u> happy, and explained that such a development seemed "incredible" to her. Having resolved many problems, she now felt more aware of her limitations

and abilities, and was ready to move forward.

One respondent had maintained sobriety for fourteen years, and related that she was rarely tempted to drink now; in fact, the smell of alcohol tended to be nauseating. She labeled herself as alcoholic, which was described as "a person that cannot handle booze." Declining health produced the most frustration in her present life, but she described herself as "basically happy."

The most positive account of present-day life came from a respondent who described herself as very happy and optimistic about the future. While ambivalent about the label of "alcoholic," she saw her own sobriety as one of the most positive steps undertaken in her life. She elaborated that the term might be useful to some people in order to "shake them up" and guide them toward less self-destructive behaviors. However, the label may also keep people "stuck" on one facet of their lives, and may stigmatize and unnecessarily frighten them. She admitted that drinking may become so habitual that the drinker finds it difficult to imagine life without alcohol, and that a change in behavior would more than likely be beneficial.

Her first year of sobriety was extremely difficult, as she explained that she had few "social skills" and consequently felt very lonely, frightened, and isolated. However, her sobriety led to a relief from her chronic depression, which was such a major improvement that no other kind of motivation toward remaining sober was

necessary. The combination of sobriety with private therapeutic work enabled her to learn how to make and keep friends and relationships, how to set and meet realistic goals, and how to allow spontaneity to have a place in her life. She related that she was quite aware that unhappiness is also a part of life, as she had experienced some great difficulties since becoming sober. Yet her heightened self-esteem and self-acceptance had enabled her to handle those difficulties.

One respondent felt herself to be "moving toward happiness," but, while she was happier now than she used to be, she felt that "it's still sort of something 'out there.'" While in AA, she "just pretty much accepted" their philosophy and definitions, but decided that alcohol was not her drug of choice upon leaving the program. Presently, she did not feel "terribly focused," but nevertheless felt satisfied with her life. She possessed reasonable goals, got "a lot of laughs out of life," and had enough sobriety and life behind her that she felt she could move forward now.

The final interviewee lost friends when she quit drinking, which she knew "intellectually" would happen. She described herself as partly sad, yet partly relieved by the development. She was also frightened because of the ensuing isolation, but felt somewhat consoled by the idea that these previous friendships were most likely lacking in meaning. In other words, they "had not been about being

friends, but about using," and she felt expendable when the friendships ended.

In her opinion, alcoholism is the result of habitual use and possibly biological factors. With regard to habitualization, she thought that "at some point, anybody who uses a chemical [is]...physically...going to get addicted." If a person was genetically disposed toward alcoholism, this addiction would emerge quickly. In a similar fashion, some people have a more difficult time trying to quit. She further defined alcoholism by stating that "if alcohol is causing a problem, then you have a problem with alcohol." This definition allows people who do not label themselves alcoholics to admit their problems, since admitting a drinking problem is easier than saying "I can't control myself." She found the AA definition to be too objective, because it concerned itself only with effects.

She stated that she simply found not drinking easier on her than drinking, and felt that the present period had been the best time of her life. Despite occasionally experiencing "real flashes of loneliness," she could even enjoy the intensity of these and similar feelings, because she knew they would not last. Her life now contained a "real sense of possibilities," in which she no longer felt the need to control everything or even to "belong." She had gained a new acceptance of herself, or, in her words, to "just be where I am."

CHAPTER VIII

SUMMARY AND CONCLUSIONS

Women who have attempted recovery in Alcoholics Anonymous were selected as the interview subjects for this research. A focus on women was chosen for three main reasons. Literature on the subject of alcoholism suggests that female alcoholics may be "different" from male alcoholics in some respects. In addition, Alcoholics Anonymous was originally formed with male alcoholics in mind (since they comprised the majority of alcoholics), although the program did not, and does not, exclude women from membership. Finally, early alcoholism research focused almost entirely on men, yet that research remains the basis for various treatment programs, especially Alcoholics Anonymous. Because of these three factors, the impact of AA on women's processes of labeling themselves as alcoholics has been explored.

The methodology utilized in this research was in-depth interviewing. A qualitative approach was chosen, since a process of labeling was the area explored. The interview questions guided, but did not dictate, the women's revelations of their past and present thoughts, feelings, attitudes, and behaviors. In this manner, a

"deep" and meaningful description of the changes in these women's lives with regard to a specific treatment program emerged.

The first area covered centered on early attitudes toward alcohol and the impact of family on the women's self-concepts. Only two of the women experienced noticeable family problems that resulted from a parent's consumption of alcohol. In both of these cases, the women grew up with an aversion to drinking. An additional pair of respondents eventually became aware that a parent drank heavily, but the drinking did not, to their knowledge, cause family problems. Neither woman related early negative attitudes toward drinking. The remaining six respondents were either oblivious to alcohol and its possible problems, or considered the drinking behavior they observed to be normal.

Two-thirds of the women described difficulties in growing up in their family of origin. The most commonly-reported feeling was a sense of not belonging or of being different from others. The often-documented isolation of "alcoholic families" and the resultant feelings of "differentness" by the children of these families appears to be a factor in the lives of many of the interviewees. Even among the four women for whom growing up appeared to be "normal," this theme seems to have been present. One of these four related her chronic depression, while another described her attempts to "fit into" various groups.

Inclusion of these data on early experiences is not meant to suggest that early events, feelings, or attitudes cause subsequent ones. While feelings, attitudes, and self-concepts can become habitual, choice is present at any given time. Past behavior can impact on and influence present behavior, but it can just as likely be disregarded. Both arguments appear to describe the data presented in this section. While the majority of interviewees did not have negative assessments of drinking while growing up, and consequently had few unfavorable experiences to dissuade them from becoming heavy drinkers, two women came from homes beset by problems resulting from a parent's drinking. Despite these experiences and an early aversion to drinking, both women became heavy drinkers themselves. The influence (or lack of influence) of early self-concepts on later ones will be discussed later in this chapter.

Chapter Five outlines the women's drinking careers and their growing "realizations" that alcohol may have become a problem. Most of the women began drinking during adolescence, with two commencing before their teenage years and two starting after the age of eighteen. Most early experiences were pleasant, although at least three women consciously used drinking as an escape: two sought to relieve stress arising from family dynamics, while the third attempted to alleviate her depression.

As the drinking progressed, control became a key issue for some of the respondents. Various consequences

had begun to be manifested, but the women had not yet decided that their drinking was cause for alarm. While each woman's alcohol intake increased, a gradual increase characterized some of the respondents, while a rather rapid accleration of drinking was typical for others.

The focal point of this chapter dealt with the women's decisions that drinking had become a problem for them. At the same time, the self-concepts in place at that time were examined. The juncture of the two focii helps to explain the path of recovery that the women chose. The most important influences on the women's realizations were other people. While a number of women had, at one point or another, considered the possibility that they might be alcoholic, the majority of women reported that observations (solicited or unsolicited), suggestions, and pressure from others impacted the most on their decisions to seek treatment. Although the choice to label themselves as alcoholics (or even as "problem drinkers") was made individually, the choice was not made in a vacuum or without corroboration and support from external social sources. An insight into why the women chose to "go along" with the label may be gleaned from terms offered by the women to describe their self-concepts at the time: insecure, co-dependent, "drained of goodness," hopeless, lost, undefined, confused, lonely, "close to the bottom," angry, belligerent, paranoid, and depressed. Only one woman reported relatively high self-esteem at the time she sought help.

The effect of Alcoholics Anonymous on the women's self-labeling comprised Chapter Six. This effect is best discerned in the positive and negative changes undergone by the women, and by the disconcerting results of the women's attempts to utilize a philosophy that did not always "fit." With only one exception, the women had entered the program with low self-esteem. Two emerged with more positive feelings (although one of the two credited her overall treatment program, rather than AA, as the reason), while one asserted that her feelings did not change. The remainder had either initially felt better but then worsened, or regressed from an already-low point.

The most frequently-reported incongruency influencing the women's decision to leave the program forms the crux of this exploration on labeling: six of the women did not consider alcohol to be their major problem. The particular conflicts with elements of the program, such as the perceived overuse of the "personal inventory," problems with AA's spiritual overtones, and especially the discomfort with its "rigidity," "dogma," and "written and unwritten rules," are perhaps subsumed by the larger issue of this basic incongruency.

One other pattern emerges from the data with regard to reasons given for exiting the program. In five cases, a specific incident or development acted as a catalyst in the decision to leave. These reasons might be viewed as justifications, in the sense that the women were seeking a way

to rationalize their leaving a less-than-beneficial line of action. However, in at least three of those cases, the women reported that, up to the time that the incident took place, positive changes were being made. In these cases, the justifications may have been thought necessary for ceasing an activity that the women simply did not want to continue.

The women's present-day feelings about themselves and the label of "alcoholic" were the final topics of the interviews. Only one woman unhesitatingly called herself "alcoholic." Similarly, only one respondent was positive that she was not alcoholic, although she nevertheless thought that she might be biologically predisposed to alcoholism. The remaining eight interviewees tended to approach the application of the label to themselves with great caution and a fair amount of uncertainty. The myriad of definitions elicited from the ten women attests to the ambiguity produced in the women who were hesitant to label themselves. Alcoholism was defined as a biological predisposition, not a biological predisposition, an inherited trait, not an inherited trait, a disease, not a disease, a way to deal with problems, a situational event, and a habit. Other ideas pointed to the consequences of heavy drinking and the problems that may ensue as indicative of alcoholism. The problem with attempting to find a definition of alcoholism is perhaps best summed up in one respondent's observation that there are probably "as many

definitions as there are alcoholics."

Labeling is a process of self-description. The conclusions that ten women, who have sought assistance for problems attributed to their consumption of alcohol, have made about themselves has been the topic of this research project. The ways in which a program, such as Alcoholics Anonymous, has impacted on members who chose not to continue has also been explored. While a number of negative assessments of AA have resulted from the interviews, the nature of this research renders such assessments understandable. One of the long-range goals of this study was an attempt to determine what women who have "dropped out" needed to facilitate the changes that they felt were necessary in their lives. Critical evaluation of where one has already "been" usually includes both positives and negatives. Nevertheless, regardless of what overall assessment of AA the women maintained, the fact that the majority enjoy a much more positive image of themselves today attests to the value of the AA experience as a process of self-discovery.

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APPENDIX A

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

1. We admitted we were powerless over alcohol--that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

APPENDIX B

OUTLINE FOR RESEARCH QUESTIONS

I. DEMOGRAPHIC DATA

- Family
- Education
- Religion
- Occupation

II. ALCOHOLISM: BACKGROUND

- When started
- Length
- Type, frequency
- Symptoms experienced
  - physical
  - emotional
- Consequences of symptoms

III. DEVELOPMENT OF LABELING AS ALCOHOLIC/SELF-CONCEPT

- When aware of "problem"
  - from self
  - from others
- Pressure felt to conform to label
- Power issues/feelings of control
- Other feelings
- Self-definition prior to AA

IV. EXPERIENCE PRIOR TO AA

- When first heard about AA
  - who suggested
  - feelings and thoughts about it
- Knowledge of AA program prior to attending
  - Twelve Steps
  - Twelve Traditions
  - disease concept of alcoholism
  - AA definition of alcoholism and alcoholics
- Knowledge of other approaches to treatment
- Experience in other treatments
  - private
  - groups
  - medicinal

V. EXPERIENCE IN AA

- How long attended
- Reactions from others upon attending
  - family, friends, etc.
  - AA members
- Self-concept changes, if any
- Pressure felt to conform
- Feelings experienced
- Progress made toward drinking problem
- Other women in program
  - number
  - connections with
- Knowledge of others who had dropped out
  - reactions of group, self, to others who had dropped out
  - knowledge of what happened to dropouts

VI. EXPERIENCE SINCE AA

- Why program left
- Reactions from others to own dropping out
- Consequences to recovery already made
- Acceptance of label
- Plan for recovery (if any)
- Self-concept now
- Pressure to conform
- Feelings of power, control
- Concept of failure

VITA

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